

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040340

FILED VS DEC 7 1959/149

STATE FILE NUMBER

Registration District No.

Primary Registration District No. 1.002

Registrar's No.

5627

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	Length of stay in 1b 79 Years	c. CITY OR TOWN Kansas City	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Luth. Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3221 Pennsylvania
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last JESSIE ROBISON			4. DATE OF DEATH Month Day Year 11 20 59			
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/9/78	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME Michael Sweeny		13b. MOTHER'S MAIDEN NAME Mary Lally		14. NAME OF HUSBAND OR WIFE William H. Robison	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Frank M. Robison, 7241 Jarboe, K.C. Mo.			
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pos op. fracture of femur</i> DUE TO (b) <i>fall</i> DUE TO (c) <i>stroke w/pts. malnutrition</i>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>hypertension, myocarditis</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <i>1949</i> to <i>1959.11.20</i> last saw her <i>11-20-59</i> Death occurred at <i>12:30 pm</i> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>Hugh A. Gestring M.D.</i>		22b. ADDRESS <i>1720 E 31st</i>		22c. DATE SIGNED <i>11-21-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/23/59	23c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Mo
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24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eyler 20 W Linwood K.C. Mo.		25. DATE RECD. BY LOCAL REG. <i>11-21-59</i>	26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DV Hynke A. G. Estwing
1220 E 31st
Va. 1-6400

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____
Wm. H. Gentry

Licensed Embalmer No. 5038

P. O. Address K.C., Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.