

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 23 1960

-60-006523

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 745 STATE FILE NUMBER

|  |  |  |  |  |   |   |  |
|--|--|--|--|--|---|---|--|
| 1. PLACE OF DEATH  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)        |   |   |  |
| a. COUNTY <b>Jackson</b>   |  | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>   |  | a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>  |   | c. CITY OR TOWN <b>Kansas City</b>  |  |
| Length of stay in 1b <b>23 Years</b>   |  | Inside Limits <b>Yes XX No</b>   |  | d. STREET ADDRESS (If outside, give location) <b>4241 College Avenue</b>                     |   | Reside on Farm <b>Yes No XX</b>   |  |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lindeman Nursing Home</b>   |  |  |  |  |   |   |  |
| 3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>M.</b> Last <b>ROBINSON</b>  |  |  |  | 4. DATE OF DEATH Month <b>February</b> Day <b>5,</b> Year <b>1960</b>                        |   |   |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>          | 7. Married <b>XX</b> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>4-14-1868</b>            | 9. AGE (last birthday) <b>91</b>   | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Engineering</b>   |  | 11. BIRTHPLACE (City and state or country) <b>Spring Hill, Kansas</b>                        |   | 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME <b>Briscoe Robinson</b>   |  |  | 13b. MOTHER'S MAIDEN NAME <b>- - - Mason</b> |  | 14. NAME OF HUSBAND OR WIFE <b>Lillith Robinson</b>                           |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>  |  | 16. SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT Address <b>Mrs. W.H. Bergfeldt, 119 E. 51st Terr. K.C. Mo.</b>                 |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b>  |  |  |  |  |   | <b>4 days</b>   |  |
| DUE TO (b) <b>Generalized Arteriosclerosis with</b>  |  |  |  |  |   | <b>years</b>  |  |
| DUE TO (c) <b>Recent Myocardial Infarction - Cerebral Thrombosis</b>   |  |  |  |  |   | <b>6-8 mos.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes mellitus</b>   |  |  |  |  |   | 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.) |   |   |  |
| 20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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   |  |
| 21. I attended the deceased from <b>1958</b> to <b>1960-2-5</b> and last saw her alive on <b>2-5-60</b> . Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |  |  |  |  |   |   |  |
| 22a. SIGNATURE (Degree or title) <b>Mary C. Colglazier, M.D.</b>   |  |  |  | 22b. ADDRESS <b>3317 E 43rd K.C. Mo</b>  |   | 22c. DATE SIGNED <b>2-6-60</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>   |  | 23b. DATE <b>Feb. 8, 1960</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Crematory</b>                                  |   | 23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri.</b>   |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>FREEMAN MORTUARY, Kansas City, Missouri.</b>   |  |  |  | 25. DATE RECD. BY LOCAL REG. <b>2-8-60</b>   |   | 26. REGISTRAR'S SIGNATURE <b>Heavenshall</b>  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Clayton K. Barnes

Licensed Embalmer No. 4793

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.