

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

20560

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Grand Primary Registration District No. 1002 Registered No. 2031
 City Kansas City, Mo. K.C. General Hosp. St. _____ Ward _____

2. FULL NAME

Robbins, Frank
 (a) Residence No. 804 Central St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 10 yrs. _____ mos. _____ da. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 22-1857

7. AGE YEARS 70 MONTHS 8 DAYS 12
 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Clinton
 (STATE OR COUNTRY) Mass.

10. NAME OF FATHER Wm. Robbins

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Maine
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Johnson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Vermont
 (STATE OR COUNTRY)

14. INFORMANT Reverend Clerk
 (Address) K.C. Gen. Hosp.

15. FILED 6/4-28 M. M. Brown REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-4-1928

17. I HEREBY CERTIFY, That I attended deceased from 3-15-28, to 6-4-28, 1928
 that I last saw him alive on 6-4-28, 1928, and that death occurred, on the date stated above, at 6145 a 53D

18. THE CAUSE OF DEATH WAS AS FOLLOWS:**
Bronchopneumonia -
secondary Sarcoma of lumbar
vertebral.
 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) Sarcoma of lumbar
vertebral (duration) _____ yrs. 3 mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
NOT AT PLACE OF DEATH

19. HAD AN OPERATION PRECEDE DEATH? Yes DATE OF 5/27/28
20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) P. E. Williams, M. D.
4 (Address) Supt. K.C. Gen. Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Washington **DATE OF BURIAL** 6-5-1928

20. UNDERTAKER O. J. Mat **ADDRESS** _____

N. B.—Every case of CAUSE OF DEATH is particularly to be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Jackson Registration District No. 399 File No.
 Township H. City Primary Registration District No. 1007 Registered No. 9431
 City H. City (No.) St. Ward)

2. FULL NAME Robbins, Frank
 (a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 4 1928

17. I HEREBY CERTIFY, That I attended deceased from 19... to 19... that I last saw him alive on 19... and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed)....., M. D.
 , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 ADDRESS 19

20. UNDERTAKER ADDRESS
W. K. Brown
 REGISTRAR

15. FILED 6/4 28 M. M. Brown 19... REGISTRAR
W. K. Brown

WRITE PLAINLY, WITH INK. THIS IS A PERMANENT RECORD.
 Every item of information should be carefully supplied. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-20560