No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILLED JUN 10 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17332

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1994

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Auto Acad 15 st / Ewing (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community Unknown years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson 48
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 1014 Forest St (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME FRANK-S ROBISON
3. (b) If veteran, name war ✓
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced ✓
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Not Known (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
About 70	—	—	hr. min.

9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation Unknown
11. Industry or business
MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Coroners Records
(b) Address Jackson Co. Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21-41 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Marsah
18. (a) Signature of funeral director Stine & McClure
(b) Address 2512 Hadin St
19. (a) May 21 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 5-11-41
year hour minute 2 40 p. M.
21. I hereby certify that I attended the deceased from Coroner, to , 19 ;
that I last saw him alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Laceration of the brain	
Due to Fracture of the skull	
Due to Auto traumatism	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 5-11-41
(c) Where did injury occur? K.C 123 Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? City Strip - Driver, lost control car. Not a collision (Specify type of place)
— While at work? (e) Means of injury 2 of 2 cars
23. Signature [illegible] (M. D. or other)
Address K.C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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~~ .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed P. G. Theisen

Licensed Embalmer No. 2361

P. O. Address 2512 Halsted

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.