

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 10094
1571
Registrar's No. _____Registration District No. 149Primary Registration District No. 1002

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:
K. C. Convalescent Home 4
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 months
 (Specify whether
 In this community 2 years
 years, months or days)

3. (a) PRINT FULL NAME ALSINA J. ROBINSON

3. (b) If veteran, name war No 3. (c) Social Security No. None
 4. Sex Fe. 5. Color or race White 6. (a) Single, widowed, married, divorced 2 Widow
 6. (b) Name of husband or wife Joseph Robinson 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Unknown
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87? hr. min.

9. Birthplace Ohio
(City, town, or county) (State or foreign country)10. Usual occupation Homemaker-Retired11. Industry or business None

12. Name John Gano
 13. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Fred Custonborder
 (b) Address 339 S. Lawn

17. (a) Removal (b) Date thereof April 8, 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park, Kansas City, Kansas18. (a) Signature of funeral director G. H. Blackman & Son, Inc.(b) Address Kansas City, Mo.

19. (a) 4-8-44 (b) N. E. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
 (If outside city or town limits, write "RURAL")
 (d) Street No. 526 Brookside 5
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6
 year 1944 hour I minute 00 P. M.

21. I hereby certify that I attended the deceased from 7-28-43
 _____, 19, to 4-6-44, 19;
 that I last saw h. alive on 4-5-44, 19;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to Atherosclerosis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: 97 **PHYSICIAN**
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

(e) Means of injury _____

23. Signature Splawey and O (M. D. or other)Address 2200 Newberry Date signed 4-8-44

00

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 *H. B. Blackman*.....

Licensed Embalmer No. *3639*.....

P. O. Address *K. C. Mo*.....

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

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