

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27916
3468
Registrar's No.

FILED AUG 26 1947
Registration District No. 1979

Primary Registration District No. 1002

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: GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 HRS. 50 MINS.
In this community 1 YR.
years, months or days (Specify whether)

3. (a) FULL NAME ROBERT ALBERT ROLLINS
3. (b) If veteran, name war No
3. (c) Social Security No. unk

4. Sex MALE
5. Color or race NEGRO
6. (a) Single, widowed, married, divorced DIVORCED
6. (b) Name of husband or wife unk
6. (c) Age of husband or wife if alive years 13 years 1898
7. Birth date of deceased AUGUST 13, 1898
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
48 11 21 hr. min.

9. Birthplace BUNCEYON MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation JANITOR

11. Industry or business

MOTHER FATHER
12. Name JAMES GREEN ROLLINS
13. Birthplace COOK COUNTY MISSOURI
(City, town, or county) (State or foreign country)
14. Maiden name MILLIE CLARKSTON
15. Birthplace COOK COUNTY MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant MOTHER: MILLIE ROLLINS
(b) Address 3228 CENTRAL

17. (a) Burial (b) Date thereof 8-20-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Linsden

18. (a) Signature of funeral director W Atkins Bros

(b) Address 1729 Sylvia

19. (a) 8-12-47 (b) Heraldine Holman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. 3228 CENTRAL
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month AUGUST day 4,
year 1947 hour 1: minute 15 P. M.
21. I hereby certify that I attended the deceased from AUGUST
4, 1947 to AUGUST 4, 1947
that I last saw h IM alive on AUGUST 4, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL VASCULAR ACCIDENT
Due to HYPERTENSIVE HEART DISEASE

Other conditions (Include pregnancy within 3 months of death)
Due to
Major findings:
Of operations 930
Of autopsy

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)
(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?

While at work (Specify type of place) (Means of injury)

23. Signature [Signature] (M. D. or other) M. D.
Address GENERAL HOSPITAL NO. 2 Date signed 8/5/47

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.....

J. J. Marlowe

Licensed Embalmer No. *3994*

P. O. Address. *2503 Highland*

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