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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17659**
Registrar's No. **2186**

Registration District No. **399** 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
(c) Name of hospital or institution:
31st. & Troost 2nd. Ch. of Christ
(d) Length of stay: In hospital or institution --
In this community 45 Years

3. (a) PRINT FULL NAME Mr. Robert F. Ives
(b) If veteran, name war None
(c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Maude Ives
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased August 21 1869

8. AGE: Years 70 Months 9 Days 5 If less than one day hr. min.

9. Birthplace Iowa

10. Usual occupation Building Contractor

11. Industry or business --

MOTHER FATHER { 12. Name Thomas Ivas
13. Birthplace Iowa
14. Maiden name Elizabeth Hays
15. Birthplace Delaware

16. (a) Informant Mrs. Maude Ives
(b) Address 3236 Tracy

17. (a) Burial (b) Date thereof May 29, 1940
(c) Place: burial or cremation Mt. Washington Cem.

18. (a) Signature of funeral director D. H. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd.

19. (a) May 29, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 3236 Tracy 2nd. Floor North
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26
year 1940 hour 12:30 minute P. M.

21. I hereby certify that I attended the deceased from Coventry to Coventry, 1940; that I last saw him alive on May 26 and that death occurred on the date and hour stated above.
Immediate cause of death Acute pulmonary congestion
hypertrophy of the heart
chronic suppurative infection & aneurysmal dilatation
of coronary occlusion

PHYSICIAN
Major findings: 9582
Of operations:
Of autopsy:

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify place of place) (Specify means of injury)
23. Signature Robert H. Miller (M. D. or other)
Address K.C. Mo. Date signed

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 George M. Collier

Licensed Embalmer No. 3839

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 this body is not embalmed, above space should be left blank.