

FILED MAR 16 1942

Registration District No. 277

Primary Registration District No. 1002

Registrar's No. 978

1. PLACE OF DEATH:

(a) County: **Jackson**

(b) City or town: **Kansas City**

(c) Name of hospital or institution: **1713 Prospect**
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution: **40 Years**
(If not in hospital or institution, write street number or location)

In this community: **40 Years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME: **Alice N. Roberts**

3. (b) If veteran, name war: **no**

3. (c) Social Security No: **NO**

4. Sex: **Female**

5. Color or race: **White**

6. (a) Single, widowed, married, divorced: **Widow**

6. (b) Name of husband or wife: **E.A. Roberts**

6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: **September 3 1864**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	77	6	6hr.min.

9. Birthplace: **Ky.**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Housewife**

11. Industry or business: _____

MOTHER FATHER { 12. Name: **William Adkins**

13. Birthplace: **Ky.**
(City, town, or county) (State or foreign country)

14. Maiden name: **Sarah May**

15. Birthplace: **Ky.**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Mrs. Mary E. Elliott**

(b) Address: **Tulsa Okla.**

17. (a) **Burial**
(Burial, cremation, or removal)

(b) Date thereof: **3-10-1942**
(Month) (Day) (Year)

(c) Place: burial or cremation: **Forest Hill**

18. (a) Signature of funeral director: **Mrs. C.L. Forster**

(b) Address: **Kansas City, Mo.**

19. (a) **March 19 1942**
(Date received local registrar)

(b) **M. M. Crowe**
(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.: **1713 Prospect**
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **9** th.
year **1942** hour **10** minute **A.** M.

21. I hereby certify that I attended the deceased from **Aug** 19**42** to **Mar 9** 19**42** that I last saw her alive on **Mar 9** 19**42** and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic Endocarditis**

Duration: **year**

Due to: **Hypertension**

Due to: **uncomplicated fracture of hip of 5 yrs standing**

Other conditions: **Had to have crutches for relief**
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: **gout**

Of operations: **L**

Of autopsy: **L**

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): **L**

(b) Date of occurrence: **L**

(c) Where did injury occur?: **L**

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

23. Signature: **W. W. Martin** (M. D. or other)

Address: **409 Cambridge Hill Mo** Date signed: **3-9-42**

361

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

