

FILED APR 25 1942
Registration District No. **399**

Primary Registration District No. **1002**

48
3
8
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:
3430 Jackson
(If not in hospital or institution, write street number or location) **/**

(d) Length of stay: In hospital or institution: _____ (Specify whether
In this community. **35 years** years, months or days)

3. (a) PRINT FULL NAME **Mrs. Lillian H. Roth**

3. (b) If veteran, No name war

3. (c) Social Security None

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Gustav A. Roth**

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

7. Birth date of deceased. **July 13, 1874**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

67 8 23 hr. min.

9. Birthplace. **Union City New Jersey**
(City, town, or county) (State or foreign country)

10. Usual occupation. **At Home**

11. Industry or business.

12. Name **Charles Baxter**

13. Birthplace. **New Jersey**
(City, town, or county) (State or foreign country)

14. Maiden name. **Ellen Wilson**

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

16. (a) Informant. **Russell Roth**

(b) Address. **3430 Jackson Avenue**

17. (a) **Burial** (b) Date thereof. **4-7-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. **Mt. Washington**

18. (a) Signature of funeral director. **Freeman Mortuary**

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

19. (a) **4-7-42** (b) **Mr. M. Crowe**
(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. **3743 Prospect Ave.**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **sixth**
year **1942** hour **9** minute **30** A.M.

21. I hereby certify that I attended the deceased from **March 30**, 19**42**, to **April 6**, 19**42**;
that I last saw h. alive on **April 6**, 19**42**,
and that death occurred on the date and hour stated above.

Immediate cause of death. **Lobar Pneumonia**

Due to **General debility**

Due to **Asphyxia**

Other conditions. **108**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

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). **no**

(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)
(e) Means of injury **D**

23. Signature **Estuyatt** (M. D. or other) _____
Address **3850 Prospect** Date signed **4-6-42**

