

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9858

State File No.

Filed APR 25 1942
Registration District No. 379

Primary Registration District No. 1002

Registrar's No. 1320

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Leads, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3621 Fremont Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 yrs.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Myrtle E. Roundtree

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife E. M. Roundtree 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Feb. 21, 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 1 10 hr. min.

9. Birthplace Paney Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business

12. Name J. E. Jordan

13. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Louella Tartison

15. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. E. M. Roundtree

(b) Address 3621 Fremont

17. (a) ~~xxxx~~burial (b) Date thereof 4/4/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brooking Cemetery

18. (a) Signature of funeral director Cato & Speaks

(b) Address 300 S. Grand

19. (a) 4-3-42 (b) M. M. Craven
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048
(c) City or town Leads, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. 3621 Fremont
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1
year 1942 hour 8 minute 05 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____

that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia 382

Diagnosis: Chr. Glomerular nephritis 2475-
Capillary hematuria
Proteinuria
Recurrent R. ovary 592
Other conditions:
(Include pregnancy within 3 months of death)

Major findings: 49 ac
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) _____
(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)
Address [Address] Date signed 4-1-42

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.....

Alwyn J. Kato

Registered Apprentice No. *321*

working under my personal supervision.

Signed.....

Roland J. Speake

Licensed Embalmer No. *3604*

P. O. Address.....

Independence

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1320

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No.

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:
3621 Freemont Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

Myrtle R. Rountree

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female

5. Color or race _____

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year _____

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day _____ hr. _____ min.

65 yrs.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 3, 1942 (b) M. M. Crowe
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town Kansas City
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1st
year 1942 hour 8 minute 05 A M.

21. I hereby certify that I attended the deceased from 10-4-1940
to 3-31-42, 19____;
that I last saw her alive on 3-31-42, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Memia Duration 3da

Due to Ch. Glomerul. nephritis

Due to Papilloferrous cyst. 2 yrs. oldenol - cacumbana

Other conditions of R. eye
(Include pregnancy within 3 months of death) Recurrent 5 yrs.

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) _____

(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 _____

23. Signature [Signature] (M.D. or other) _____

Address [Address] Date signed _____

SUPPLEMENTARY

9858