

FILED SEP 3 1942

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3175

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: K.C. General Hospital No. 10  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day  
(Specify whether years, months or days)

In this community 25 yrs  
(Specify whether years, months or days)

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. 1618 Washington  
(If rural, give location)

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

3. (a) PRINT FULL NAME Lillie Roberts

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 21st  
year 1942 hour 7 minut 54 P. M.

21. I hereby certify that I attended the deceased from 8-20-42, 19... to 8-21-42, 19...  
that I last saw h er alive on 8-21-42, 19...  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color of race W.

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

6. (b) Name of husband or wife Claude 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased May 13 1895  
(Month) (Day) (Year)

Immediate cause of death.....  
Cerebral hemorrhage

Due to..... 83a

Due to.....

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

8. AGE: Years 47 Months 3 Days 8  
If less than one day hr. min.

9. Birthplace Texas 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business at home

12. Name John W Askew

13. Birthplace Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Hoffmann

15. Birthplace Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant John F Askew

(b) Address 11883 Kungler

17. (a) Burial (b) Date thereof 8-24-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Floral Hill

18. (a) Signature of funeral director B. W. Askew

(b) Address K.C. Mo

19. (a) 8-24-42 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations.....

Of autopsy.....

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 0

23. Signature Dr. M. P. Thom (M. D. or other).....  
Address Med. Dir. K.C. Gen. Hospital K.C. Mo. Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SEP 20 1977

**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 W. B. Blackman

Licensed Embalmer No. 2244

P. O. Address.....

**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.**