V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 1 1945

State File No. 26448

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3450

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home, 5215 Lyons (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 77 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 42

(c) City or town K. C. (If outside city or town limits, write "RURAL") 7

(d) Street No. 5215 Lyons (If rural, give location) 6

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Robert Charles Heath

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased Nov. 8, 1867 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
77	9	8	hr. min.

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

10. Usual occupation Retired Plasterer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Martha Levine
15. Birthplace Unknown (City, town, or county) 0 (State or foreign country)

16. (a) Informant Grace May Fanning

(b) Address 5215 Lyons

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Blackman's

(b) Address 2825 Indep. Blvd.

19. (a) 8-17-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug day 16 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from 8/16, 1945, to 8/16, 1945; that I last saw him alive on 8/15, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic valvular heart disease	?
Due to	
Due to	
Other conditions Chronic Cirrhosis of liver (Include pregnancy within 3 months of death)	?

Major findings:
Of operations
Of autopsy 1245

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. Shillaeus (M. D. or other) MD

Address 5400 St John Av Date signed 8/20/45

(Licensed Embalmer's Statement on Reverse Side)

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 H D Blackman

Licensed Embalmer No. 3639

P. O. Address K. C. 1, 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, fact should be so stated above.