S. No. 2
M—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 23 1947

Registration District No. 199

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 34416
Registrar's No. 3854

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: General Hospital No. 1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: Receiving Ward
(Specify whether
In this community: 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 312 Main 8
(If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William Roberts
3. (b) If veteran, name war: no
3. (c) Social Security No.: none

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Aug 21 1873 (Month) (Day) (Year)

8. AGE: Years 74 Months 0 Days 15 If less than one day hr. min.

9. Birthplace: Rome N.Y. (City, town, or county) (State or foreign country)
10. Usual occupation: hunter
11. Industry or business: retired
MOTHER FATHER
12. Name: William Roberts
13. Birthplace: England (City, town, or county) (State or foreign country)
14. Maiden name: Mary Prosser
15. Birthplace: England (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Ruth Rich
(b) Address: 1601 N. Park St Louis Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 9/9-47 (Month Day) (Year)
(c) Place: burial or cremation: East St Louis Ill
18. (a) Signature of funeral director: Delbert Funeral Home
(b) Address: 901 E 5th St
19. (a) 9-9-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 6 year 1947 hour 5 minute 5 P.M.

21. I hereby certify that I attended the deceased from 9-6, 1947, to 9-6, 1947, that I last saw him alive on 9-6, 1947, and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Acute and chronic myocardial infarction with acute cardiac failure
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: N/A
Of autopsy: See above

PHYSICIAN
Underline the cause of 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: [illegible] (M. D. or other) MD
Address: Med. Dir. Gen'l Hosp. Date signed: 9-8-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Dr. Keller

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 Roy E Snow

Licensed Embalmer No. 2560

P. O. Address KC 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.