

Health,
, & Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

445770
STATE FILE NUMBER
5897

FILED JAN 8 1958

Registration District No. 149 Primary Registration District No. 1202 Registrar's No.

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4605 Jarboe		Length of stay in 1b 35 Years	d. STREET ADDRESS (If outside, give location) 4605 Jarboe		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MILO Middle Last ROBERTS			4. DATE OF DEATH Month Dec. Day 12, Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1871 Oct. 19, 1872	9. AGE (In years last birthday) 85 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Parole Officer	11. BIRTHPLACE (City and state or country) Bates Co. Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME James H. Roberts		13b. MOTHER'S MAIDEN NAME Virginia E. Coppage		14. NAME OF HUSBAND OR WIFE Lydia Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-22-0333		17. INFORMANT Smithy Address Mrs. Verdna Smithy, Bethel, Kansas	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure. Valvular heart disease. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 24 hours 42-14
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at 8:20 P.M.		July 6 1957 to 12-12-57		and last saw ^{him} alive on 12-12-57	
22a. SIGNATURE (Degree or title) Hollis S. Thomas, M.D.			22b. ADDRESS 306 E. 12th St. Kansas City, Mo.		22c. DATE SIGNED 12-13-57.
23a. BURIAL, CREMATION, REMQVAL (Specify) Burial		23b. DATE 12-14-1957	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS Freeman Mortuary, Kansas City, Mo.			25. DATE RECD. BY LOCAL REG. 12-13-57	26. REGISTRAR'S SIGNATURE new Minshall	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Hollis S. Thomas

V
2

Dr. H. H. Adams
Angelo Bellotti
Ref. No. 3:30000000

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Walter H. Carwin*

Licensed Embalmer No. *4352*
P. O. Address *K. C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.