

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Dr. S. W. Day  
3126 Jefferson  
1015 E. North  
REC'D

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

31516  
Do not use this space

1. PLACE OF DEATH OCT 15 1938

(a) County Jackson 2 Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1007  
 (c) City Kansas City 1 (d) Street No. 2031 Summit  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 3813

2. PRINT FULL NAME Mrs. Mary E. Roberts 163

(a) Residence, No. 2031 Summit St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF No Record  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 5, 1860  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
78 6 22 4  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 28, 1938  
 22. I HEREBY CERTIFY, That I attended deceased from March 15, 1938, to Sept. 28, 1938  
 I last saw her alive on Sept. 27, 1938. Death is said to have occurred on the date stated above, at 9:05 a. m.  
 The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance:  
Concho-Vascular Renal  
Chronic Myocardial  
Insufficiency  
Samuelty 131

12. BIRTHPLACE (CITY OR TOWN) Davenport, 1  
 (STATE OR COUNTRY) Iowa 9

FATHER 13. NAME James McCann 9

14. BIRTHPLACE (CITY OR TOWN) No Record 9  
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME No Record

16. BIRTHPLACE (CITY OR TOWN) No Record  
 (STATE OR COUNTRY)

17. INFORMANT Mrs. Flora M. Koup  
 (ADDRESS) 2031 Summit

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Hope DATE Sept. 30, 1938

19. FUNERAL DIRECTOR (NAME) QUIRK & TOBIN COMPANY  
 (ADDRESS) Kansas City, Mo.

20. FILED Sept 30, 1938 M. M. Crowe  
 Local Registrar.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) W. C. Langley M. D.  
 (Address) 1014 Angyle Bldg.

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**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.....

Licensed Embalmer No.....

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, above space should be left blank.**