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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31043**  
Registrar's No. **3606**

Registration District No. **399** Primary Registration District No. **1002**

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

**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: St. Luke's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 days |  
In this community 15 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME ROBERT ORD CHRISTIAN JR.  
3. (b) If veteran, name war N/A 3. (c) Social Security No. N/A

4. Sex Male 5. Color or race white 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 April 3 1928  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
181 13 5 11 hr. min.

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

10. Usual occupation at home

11. Industry or business school

12. Name Dr. R. O. Christian

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

14. Maiden name Alice Snyder

15. Birthplace Fort Scott, Kansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Sheepen and Co

(b) Address Jala Kansas

17. (a) Jala Kansas (b) Date thereof 9-16-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jala Kansas

18. (a) Signature of funeral director Stine-melchior

(b) Address Kansas city mo

19. (a) Sept. 16, 1940 M. M. Grove  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Kansas (b) County \_\_\_\_\_  
(c) City or town Jala  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month September day 15  
year 1940 hour 8 minute 50 P. M.

21. I hereby certify that I attended the deceased from Sept. 1, 1940, to Sept. 15, 1940;  
that I last saw him alive on Sept. 15, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous meningitis  
Duration of death Aug. 19, 1940

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations none

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)  
(e) Means of injury 1

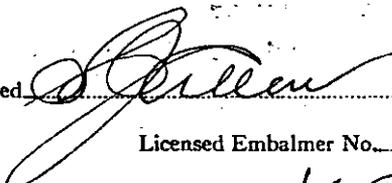
23. Signature Paul R. Deachenor (M. D. or other) MD  
Address 1630 Professional Bldg Date signed 9-15-40

PHYSICIAN  
Underline the cause to which death should be charged statistically.

**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. 1415

P. O. Address K. E. May

**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.**