

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

FILED DEC 17 1940

1. PLACE OF DEATH: **Jackson**  
 (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 **K.C. General Hospital**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **2 days** (Specify whether  
 In this community **Life** years, months or days)

3. (a) PRINT FULL NAME **ROBERT N. BEAVER**  
 3. (b) If veteran, name war **---** 3. (c) Social Security No. **NO**

4. Sex **M.** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widower**  
 6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **--** years  
 7. Birth date of deceased **Feb. 22nd, 1863**  
 (Month) (Day) (Year)

8. AGE: Years **77** Months **8** Days **21** If less than one day  
 hr. min.

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

10. Usual occupation **None**

11. Industry or business  
 12. Name **UNKNOWN BEAVER**  
 13. Birthplace **UNKNOWN**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **UNKNOWN**  
 15. Birthplace **UNKNOWN**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **MR. CHAS CRABTREE**  
 (b) Address **1412 TROOST KANSAS CITY MO**  
 17. (a) **REMOVED** (b) Date thereof **11-14-40**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Joseph, Mo.**  
 18. (a) Signature of funeral director **F. B. FLEMING & SON INC.**  
 (b) Address **St. Joseph, Mo.**  
 19. (a) **11-14-40** (b) **M. M. Craive**  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Jackson**  
 (c) City or town **Kansas City**  
 (If outside city or town limits write "RURAL")  
**0** **1412 Troost Avenue**  
 (d) Street No. (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **Nov.** 13th day  
 year **1940** hour **10** minute **A.M.** M.  
 21. I hereby certify that I attended the deceased from **11-11-40**, 19\_\_\_\_, to **11-13-40**, 19\_\_\_\_;  
 that I last saw him alive on **11-13-40**, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
**Acute dilatation and hypertrophy of Heart; Coronary sclerosis**  
 Due to **Chronic arteriosclerosis**  
 Due to \_\_\_\_\_  
 Other conditions **Chronic passive congestion of liver and early cirrhosis**  
 (Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy **See above**  
 PHYSICIAN **1241A**  
 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?  
 While at work? \_\_\_\_\_ (Specify type of place) Means of injury **1**  
 23. Signature **Drury R. Brown** (M. D. or other) \_\_\_\_\_  
 Address **Med. Dir. K.C. Gen. Hosp.** Date signed \_\_\_\_\_

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

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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.**