

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 201 Primary Registration District No. 5280 Registrar's No. 44

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Liberty Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Odd Fellows Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 4 yrs.
 years, months or days)

3. (a) PRINT FULL NAME Fountain G. Roberts

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Wid. 26. (b) Name of husband or wife Emma Roberts 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased Nov. 27 1875
(Month) (Day) (Year)8. AGE: Years 65 Months 4 Days 25 If less than one day
hr. _____ min.9. Birthplace Sheby Co. Ia.
(City, town, or county) (State or foreign country)10. Usual occupation Engineer

11. Industry or business _____

12. Name John Roberts13. Birthplace No Record
(City, town, or county) (State or foreign country)14. Maiden name No Record15. Birthplace No Record
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. Florence Nesterson(b) Address 709 W. 77 K.C. Mo.17. (a) Burial (b) Date thereof 4-22-41
(Burial, cremation, or removal) (Month) (Day) (Year)
Mt. Washington c. Mo.18. (a) Signature of funeral director Mrs. C. L. Forster(b) Address 918 Brooklyn KC Mo.19. (a) April 22, 41 (b) Allen Early
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24
 (c) City or town Liberty Missouri 0
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. Odd Fellows Home 0
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 22
year 7 hour 52 minute _____ a. M.21. I hereby certify that I attended the deceased from See me 1
19 37 to April 22, 1941;
that I last saw him alive on April 21, 1941;
and that death occurred on the date and hour stated above.Immediate cause of death Paralysis Agitans
(Paralysis Agitans)

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

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?
926 _____While at work? _____ (Specify type of place)
(e) Means of injury _____23. Signature J. H. Matthews (M. D. or other) 0
Address Liberty Mo Date signed 4/24

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 2-12-41

INDIVIDUAL REG. D.

1941-42

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed L. H. Wise

Licensed Embalmer No. 2570

P. O. Address Kansas City, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14294

Registration District No. 201

Primary Registration District No. 2280

Registrar's No. 44

1. PLACE OF DEATH:

- (a) County Clay
- (b) City or town Liberty
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution _____ (Specify whether
years, months or days)

- 3. (a) PRINT FULL NAME Louisa G. Roberts
- 3. (b) If veteran, name war _____
- 3. (c) Social Security No. _____

- 4. Sex m 5. Color or race w
- 6. (a) Single, widowed, married, divorced wid
- 6. (b) Name of husband or wife _____
- 6. (c) Age of husband or wife if alive 1875 years
- 7. Birth date of deceased Nov 27 1876
(Month) (Day) (Year)

- | | | | | |
|---------|-----------------|-----------------|----------------|--|
| 8. AGE: | Years <u>65</u> | Months <u>4</u> | Days <u>25</u> | If less than one day
hr. _____ min. _____ |
|---------|-----------------|-----------------|----------------|--|

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

10. Usual occupation _____

11. Industry or business _____

- MOTHER FATHER
- 12. Name _____
 - 13. Birthplace _____ (City, town, or county) (State or foreign country)
 - 14. Maiden name _____
 - 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 24-41 (b) Helen Early
(If he received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
- (c) City or town _____ (If outside city or town limits, write "RURAL")
- (d) Street No. _____ (If rural, give location)
- (e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 22
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN _____

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) (e) Means of injury _____

23. Signature J. H. Mathews (M. D. or other)
Address Liberty MO Date signed _____

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

SUPPLEMENTAL

S-14294