

FILED NOV 19 1942 149

Registration District No. ....

Primary Registration District No. 1002

Registrar's No. ....

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:  
3516 Summit, Cresthaven Home  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 years  
(Specify whether years, months or days)  
 In this community 12 years

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")  
 (d) Street No. 3516 Summit  
(If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Emily G. Robertson

(b) If veteran, name war No (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 2 Widowed

6. (b) Name of husband or wife Dr. Charles H. Robertson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 6 1861  
(Month) (Day) (Year)

8. AGE: Years 81 Months 5 Days 30 29 hr. min.

9. Birthplace Gentry Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Samuel Patton

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 J. C. Barber

(b) Address 4915 Mission Road, Johnson Co., Mo.

17. (a) Removal (b) Date thereof 11-7-1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eagleville, Mo.

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Mo.

19. (a) 11-5-42 (b) M. M. Groves  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 5  
 year 1942 hour 8 minute 45 A. M.

21. I hereby certify that I attended the deceased from 1  
1924 to Nov 5 1942  
 that I last saw him alive on Sept 10 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death acute Cardiac Decompensation

Due to Ch. Cordis-Vasculis & renal at heart - 12 yrs

Due to \_\_\_\_\_  
 Other conditions No other  
(Include pregnancy within 3 months of death)

Duration  
 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 M. H. Boyles (M.D. number) \_\_\_\_\_  
 Address 11337 Prof. Bldg Date signed 11/5/42

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

MOTHER FATHER

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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 Claude W. Chiles

Licensed Embalmer No. 3473

P. O. Address 76 E. 7th St.

**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.**