

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 16 1946 THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30521**
Registrar's No. **3819**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **In Drug Store at 3200 Troost Avenue**
(d) Length of stay: **4 Years.**
In this community **4 Years.**

3. (a) PRINT FULL NAME **Robert H. WHITE**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **491-10-8288.**

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife **Bertha Belle Bacon White**
6. (c) Age of husband or wife if alive **29** years
7. Birth date of deceased **March 8th, 1897.**

8. AGE:	Years	Months	Days	If less than one day
	49	5	26	hr. min.

9. Birthplace **Winterset, Iowa**
10. Usual occupation **Mechanic (Assembler)**
11. Industry or business **Trailer Mfg. Co.**

MOTHER FATHER {
12. Name **Robert W. White**
13. Birthplace **Bernard County, Illinois**
14. Maiden name **Melvina Watkins**
15. Birthplace **Bernard County, Illinois**
16. (a) Informant **Mrs. Bertha Robeson, sister**
(b) Address **1802 Claremont, Independence**
17. (a) **Cremation** (b) Date thereof **9/7/46.**
(c) Place: burial or cremation **Cremation Elmwood**
18. (a) Signature of funeral director **Millody-McGilley-Eylar**
(b) Address **1800 Linwood, Kansas City Mo.**
19. (a) **9-6-46** (b) **Steraldine Holmes**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **1307 Pennsylvania**
(e) Citizen of foreign country? **No.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **September** 4th day
year **1946** hour **6:12** minute **P.M.**
21. I hereby certify that I attended the deceased from **DEPUTY CORONER**
that I last saw him alive on _____, 19____, to _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Subarachnoid hemorrhage**
Due to **hemorrhage**
Due to **Cause unknown - pending**
Other conditions **pending**
Major findings: **See Above**
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work _____
23. Signature **A.E. Upsher**
Address **2800 Main**

STATEMENT BY LICENSED EMBALMER

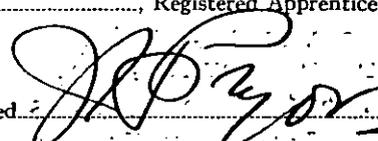
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Dean Cole

Registered Apprentice No. 408

working under my personal supervision.

Signed



Licensed Embalmer No. 2799

P. O. Address KC

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3819

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:
Drug Store, 3200 Prospect
(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 Robert H. White

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 9-6-46 Straldine Holmes
(Date 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 Sept day 4 year 1946 hour 6 minute 12 P. M.

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

Immediate cause of death Subarachnoid hemorrhage
 Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 168

Major findings: Of operations _____

Of autopsy Supplementary

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Homicide

(b) Date of occurrence 9-4-46

(c) Where did injury occur A.C. Jackson, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public place

While at work? no (Specify type of place) (e) Means of injury struck during fight

23. Signature A. E. Upsher (M. D. or other)

Address 2800 Main Date signed 9-6-46

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

MOTHER FATHER

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30521

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County.....
 (b) City or town.....
(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 in this community..... years, months or days)

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.....

3. (a) PRINT FULL NAME.....

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

5. Color or race..... 6. (a) Single, widowed, married, divorced.....
 4. Sex.....
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day
 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

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.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b).....
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....
 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....
 Due to.....
 Due to.....

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

Major findings:
 Of operations.....
 Of autopsy.....

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?.....
(Specify type of place)
 While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....
 Address..... Date signed.....

MOTHER FATHER