

No. 2  
12-45  
17-39  
47070

FILED MAR 9 1948

Registration District No. 176

Primary Registration District No. 5568

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City *Bl. & J. W.*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
520 South Brookside  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community 39 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson *48*  
(c) City or town Kansas City *0*  
(If outside city or town limits, write "RURAL")  
(d) Street No. 520 South Brookside *0*  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17  
year 1948 hour 5 minute 17 P. M.  
21. I hereby certify that I attended the deceased from 2/10, 1948, to 2/17, 1948  
that I last saw him alive on 2/17, 1948  
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Lloyd George Roberts  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Nell Roberts 6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased Sept 16 1877  
(Month) (Day) (Year)

Immediate cause of death:  
Chronic valvular Heart Disease *6 M*

8. AGE: Years 70 Months 5 Days 1 If less than one day hr. min.

Due to Chronic Syphilis  
Due to.....

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

10. Usual occupation Iron Worker

11. Industry or business.....

MOTHER FATHER  
12. Name Lovering Roberts  
13. Birthplace unknown (City, town, or county) (State or foreign country)  
14. Maiden name Ida McCulley  
15. Birthplace unknown (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations 13/18  
Of autopsy.....  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Nell Roberts  
(b) Address 520 So. Brookside

17. (a) Burial (b) Date thereof Feb. 20 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Mrs. C.L. Forster  
(b) Address 918 Brooklyn

19. (a) 2-19-48 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

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? 0  
(Specify type of place) (c) Means of injury  
23. Signature R. A. Williams (M. D. or other)  
Address 5400 S. Palm Ave Date signed 2/18 48

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

Dr. R.A. Williams  
St. John & Hardesty

Be 2639  
2:30 to 5 PM

**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 Jerry A. Minor  
Licensed Embalmer No. 4496  
P. O. Address 918 Brooklyn, K.C. 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.

Registration District No. 146

Primary Registration District No. 5568

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Blue  
(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

3. (a) PRINT FULL NAME Lloyd S. 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 m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Sept 16 1918  
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days \_\_\_\_\_  
(if less than one day)

hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Pa  
(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 \_\_\_\_\_

13. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 \_\_\_\_\_  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

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

SUPPLEMENTARY

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

MOTHER FATHER

5242 1948