

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1402

STATE FILE NUMBER

357

FILED FEB 13 1958

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY <b>Rural Gallatin Twnshp. 1</b> OR <del>Watts</del> <b>Kansas City, Mo.</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen'l Hosp. #1</b>		Length of stay in lb <del>12</del> <b>12 days</b>	d. STREET ADDRESS (If outside, give location) <b>104 W. Taylor</b>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Grover</b> Middle Last <b>Roberts</b>			4. DATE OF DEATH Month <b>1</b> Day <b>18</b> Year <b>1958</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-1884</b>	9. AGE (In years lost birthday) <b>73</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Camp Cook Construction Crew</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William W. Roberts</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Jean Dillinger</b>	14. NAME OF HUSBAND OR WIFE <b>Florence Roberts</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>496-16-1290</b>	17. INFORMANT Address <b>Mrs. Florence Roberts 104 W. Taylor</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>492*</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic heart disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>Jan. 6, 1958</b> to <b>Jan. 18, 1958</b> and last saw <sup>him</sup> alive on <b>Jan. 18, 1958</b> Death occurred at <b>5:25 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>R. I. Burns, M.D.</b>	22b. ADDRESS <b>24th &amp; Cherry</b>	22c. DATE SIGNED <b>1-20-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/23/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>White Chapel Mem Gdns. Clay Co., Missouri</b>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <b>D.W. Newcomers Sons</b>	ADDRESS <b>WKC Chapel</b>	25. DATE RECD. BY LOCAL REG. <b>1-23-58</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

B. I. Burns

All diseases in Part I must be causally related.



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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed ..... *John Kalsbeek* .....

Licensed Embalmer No. *4949* .....

P. O. Address *No. Kansas City* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.