

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

7 / 17805  
State File No. \_\_\_\_\_  
Registrar's No. **4403**

Registration District No. \_\_\_\_\_  
Secondary Registration District No. \_\_\_\_\_

FILED DEC 17 1940

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: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Days (Specify whether  
In this community Non-Resident  
years, months or days)

3. (a) PRINT FULL NAME Mrs. Grace Dewar Robertson

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

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Henry Robertson 6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased Dec. 17, 1867  
(Month) (Day) (Year)

8. AGE: Years 71 Months 17 Days 2 If less than one day  
hr. min.

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

10. Usual occupation Dress Maker

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

MOTHER FATHER { 12. Name Thomas Dewar

13. Birthplace Oil City, Pa.  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Woodruff

15. Birthplace Oil City, Pa.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. William Allen

(b) Address Pleasant Hill, Mo.

17. (a) Burial (b) Date thereof 11-20-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Hill, Mo.

18. (a) Signature of funeral director Brownfield Funeral Home

(b) Address Pleasant Hill, Mo.

19. (a) 11-18-40 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass  
(c) City or town Pleasant Hill  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 18 - year 40  
hour \_\_\_\_\_ minute 9:20 P M.

21. I hereby certify that I attended the deceased from 11-16-40  
19\_\_\_\_, to 11-18-40, 19\_\_\_\_;  
that I last saw her alive on 11-18-40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Dyspnea Secondary to Pericarditis  
Due to \_\_\_\_\_  
Acute Sarcocystis Appendicitis  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 121

Major findings: Of operations \_\_\_\_\_

Of autopsy above

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) (e) Means of injury \_\_\_\_\_  
23. Signature M. M. Brown (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

Ja. 2450

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**