

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30913

State File No.

FILED SEP 24 1954

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4117</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give town or townships) <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>18 mo</u>		c. CITY OR TOWN <u>Blue Springs</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) <u>Miss Rose Nur Home 3918 Charlotte</u>				e. STREET ADDRESS (If rural, give location) <u>Rural. 1 Mile West</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sallie</u>		b. (Middle) <u>Lee</u>		c. (Last) <u>White</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 26 1954</u>	
5. SEX <u>Fm</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>July 22 1867</u>	
9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months		IF UNDER 1 HR. Hours		Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired O A P</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Independence Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Arthur Stayton</u>			13b. MOTHER'S MAIDEN NAME <u>Harriett Rule</u>			14. NAME OF HUSBAND OR WIFE <u>Deceased George</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Henry White Blue Springs Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized A. & S. changes</u> DUE TO (c) <u>Genl. Senile Changes, myocardial failure</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u> <u>Several yrs</u> <u>3 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan 1953</u> to <u>Aug 26, 1954</u> , that I last saw the deceased alive on <u>Aug 24, 1954</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Harold M. Roberts, M.D.</u>				23b. ADDRESS <u>1103 Grand, Kan City, Mo.</u>		23c. DATE SIGNED <u>8-27-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 28-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Blue Springs</u>		24d. LOCATION (City, town, or county) (State) <u>Blue Springs Mo</u>	
DATE REC'D BY LOCAL REG. <u>8-27-54</u>		REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Webb Funeral Home Blue Springs Mo</u> <u>Roberts</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Harold M. Roberts MD

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..... *R B Webb*

Licensed Embalmer No. *235*

P. O. Address *Blue Springs*

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.