

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 8 1959

59-029731
STATE FILE NUMBER

Registration District No. 167 Primary Registration District No. 9040 Registrar's No. 217

1. PLACE OF DEATH a. COUNTY <u>Livingston</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, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in lb <u>2 weeks</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Susan Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4723 Campbell</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>STELLA V. ROBERTS</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>27</u> Year <u>1959</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4/24/1879</u>
9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Apartment House owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	11. BIRTHPLACE (City and state or country) <u>Caldwell Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>		13a. FATHER'S NAME <u>William P. Morris</u>	
13b. MOTHER'S MAIDEN NAME <u>Emma Jane Brock</u>		14. NAME OF HUSBAND OR WIFE <u>Walter Roberts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>500-22-6984</u>	
17. INFORMANT <u>Mrs. Grover Davis, Braymer Mo</u>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		<u>2 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive Vascular Disease</u>	<u>10 yrs</u>
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
21. I attended the deceased from <u>1 Sept Aug 59</u> to <u>27 Aug 59</u> and last saw her ^{her} alive on <u>26 Aug 59</u> Death occurred at <u>8:30 Pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>V O Vandiver M.D.</u> (Degree or title)	22b. ADDRESS <u>Chillicothe Mo</u>	22c. DATE SIGNED <u>31 Aug 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>8/30/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen cemetery</u>
24. FUNERAL DIRECTOR <u>Michael Funeral Home, Braymer, Mo.</u> ADDRESS		23d. LOCATION (City, town, or county) (State) <u>Braymer, Mo.</u>
25. DATE RECD. BY LOCAL REG. <u>Aug 31-59</u>		26. REGISTRAR'S SIGNATURE <u>Francis B Neill</u>

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

SEP 8 1969

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No. _____

~~working under my personal supervision.~~

Student _____
Signature of Student Embalmer

Signed *Geneb. Michael.*

Licensed Embalmer No. *4340*

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