

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032552

FILED VS SEP 23 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4260 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CLAY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 6 DAY	c. CITY OR TOWN NORTH KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 430 east 31st St. North Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ANTHONY W. ROBERTSON			4. DATE OF DEATH Month Day Year AUGUST 30 1959
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-2-18
9. AGE (last birthday) 50 40		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Grain Storage Co.	11. BIRTHPLACE (City and state or country) Republic, Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Herman Robertson	
13b. MOTHER'S MAIDEN NAME Anna C. Attendorf		14. NAME OF HUSBAND OR WIFE Dormilee Robertson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes B-5-40 To 7-18-45		16. SOCIAL SECURITY NO. 495-01-7203	17. INFORMANT Official Records, VA Hospital, K.C., Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute gastric dilation DUE TO (b) Hepatic insufficiency DUE TO (c) Nutritional cirrhosis 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			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <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
21. <input checked="" type="checkbox"/> attended the deceased from 8-24-59 to 8-30-59 and last saw him live on 8-30-59 Death occurred at 11:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) ALBERT L. CHASSON, MD.		22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 8-31-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9/2/59	23c. NAME OF CEMETERY OR CREMATORY NATIONAL Cem	23d. LOCATION (City, town, or county) (State) FT. LEAKE WORTH KS
24. FUNERAL DIRECTOR D.W. Newman	ADDRESS Sou W.K.C.	25. DATE RECD. BY LOCAL REG. 9-1-59	26. REGISTRAR'S SIGNATURE Irene Marshall

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

John W. Hale

Licensed Embalmer No. 494

P. O. Address No. Kans

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.