

FILED VS DEC 15 1959

STATE NUMBER

Registration District No. 63 Primary Registration District No. _____ Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <u>CHARITON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CHARITON</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>TRIPLETT T.W.P.</u>		Length of stay in 1b		c. CITY OR TOWN <u>TRIPLETT</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4 MI WEST</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4 MI WEST</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>CHANT</u> Middle <u>A.</u> Last <u>Robertson</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>11</u> - Year <u>1959</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-30-1992</u> <u>67</u>		9. AGE (last birthday) 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) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>TINA MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>STERLING P. BERTSON</u>			13b. MOTHER'S MAIDEN NAME <u>AMANDA J. BOLEY</u>			14. NAME OF HUSBAND OR WIFE <u>FRANCIS. ROBERTSON.</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>-</u>		17. INFORMANT <u>Mrs Robertson, Triplett Mo.</u>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>CORONARY EMBOLISM</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS</u>		
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 _____ 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. I attended the deceased from <u>JUNE 1946</u> to <u>DEC. 11 1959</u> and last saw him alive on <u>DEC. 10 1959</u> Death occurred at <u>3:00 A.M. DEC. 11 3:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Kenneth J. Rosencrance D.O.</u>				22b. ADDRESS <u>TRIPLETT MO.</u>			22c. DATE SIGNED <u>12-12-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE <u>12-14-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ELM WOOD CREMATORY</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO.</u>			
24. FUNERAL DIRECTOR <u>L. E. McClure Brunswick Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Dec 12-59</u>		26. REGISTRAR'S SIGNATURE <u>Lowie Smith.</u>			

Remond L. Rosencrance

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 13 1959

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 L. E. McCurry

Licensed Embalmer No. 4806

P. O. Address Brunswick

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.