

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001606

FILED VS JAN 30 1961

149

1002

166

STATE FILE NUMBER

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

AMENDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY JACKSON		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		a. STATE Mo		b. COUNTY Jackson	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson Co. Hosp		Length of stay in lb 6 wks		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mae Middle - Last Roberts		4. DATE OF DEATH Month Jan Day 9 Year 1961		d. STREET ADDRESS (If outside, give location) 6501 E. 24th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-19-1893	9. AGE (last birthday) 67	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (City and state or country) OZARK, Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Joseph Asbury			13b. MOTHER'S MAIDEN NAME Sarah Robinson		14. NAME OF HUSBAND OR WIFE William L.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. _____		17. INFORMANT Frank Roberts 11109 E. 83rd Address Raytown, Mo		
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) _____			DUE TO (b) _____			DUE TO (c) _____	Arteriosclerosis Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							Unknown
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 11-30-60 to 1-9-61 and last saw her him alive on 1-8-61							
Death occurred at 3 15 p on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) J.P. McCalla, M.D.				22b. ADDRESS 6312 Raytown Rd. Raytown Mo.		22c. DATE SIGNED 1-9-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-12-1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		23d. LOCATION (City, town, or county) (State) Kansas City Missouri	
24. FUNERAL DIRECTOR Floral Hills Mem, Chapels, Inc ADDRESS K.C. MO			25. DATE RECD. BY LOCAL REG. 1-11-61		26. REGISTRAR'S SIGNATURE Ruth Long		

DATE AMENDED _____
 INSTEAD OF _____
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS _____
 SHOULD READ _____
 BY AFFIDAVIT OF _____
 MEDICAL CERTIFICATION **P. Mc Calla**

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 John R. Sidman

Licensed Embalmer No. 4531

P. O. Address Kansas City, 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.