

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012732
STATE FILE NUMBER

AMENDED Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 443

FILED MAY 8 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>De Kalb</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>46 years 10 months</u>	c. CITY OR TOWN <u>Maysville</u> Inside Limits <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph State Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Unknown</u> Reside on Farm <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle Last <u>Roberts</u>			4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul. 5, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer before 1914 then patient</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>patient</u>	11. BIRTHPLACE (City and state of country) <u>Missouri</u>
13a. FATHER'S NAME <u>Richard P. Roberts</u>		13b. MOTHER'S MAIDEN NAME <u>Elissa Park</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</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>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
17. INFORMANT <u>Records St. Joseph</u>			Address <u>St. Joseph</u>
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 thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Artery Sclerosis</u>			<u>Unknown</u>
DUE TO (c) <u>Generalized arteriosclerosis</u>			-
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Dementia praecox diagnosed in 1914. Fractured h. hip April 23, 1961</u>			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 checked="" 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.) <u>Fell while dressing on DW-9</u>	
20c. TIME OF INJURY Hour <u>7:30</u> a.m. Month, Day, Year <u>4/13/61</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>hospital ward</u>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>St. Joseph State Hosp</u>	COUNTY <u>Buchanan</u>	STATE <u>Mo</u>
21. I attended the deceased from <u>vicined the body</u> and last saw her/him on <u>4-27-61</u> Death occurred at <u>6:45</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <u>Mary D. Ames, M.D.</u>		22b. ADDRESS <u>St. Joseph State Hospital</u>	22c. DATE SIGNED <u>4/27/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>4-27-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maysville Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>Maysville Mo.</u>
24. FUNERAL DIRECTOR <u>Nestor Bowman, St Joseph Mo</u>		25. DATE RECD. BY LOCAL REG. <u>April 29, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>

M.B. Ames, M.D. MEDICAL CERTIFICATION

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 William Spalding

Licensed Embalmer No. 4535

P. O. Address St Joseph 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.