

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028606

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_

149

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

3686

FILED JUL 22 1963

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY, MISSOURI</b>		Length of stay in 1b <b>10 years</b>	c. CITY OR TOWN <b>KANSAS CITY, MO.</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL, KC, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3711 E. 21 St. Kc, Mo.</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERNETHER THEODORE ROBERTS</b>		4. DATE OF DEATH Month Day Year <b>June 30, 1963</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/14/05</b>
9. AGE (last birthday) <b>57</b>		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) <b>PORTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PORTER</b>	11. BIRTHPLACE (City and state or country) <b>KANSAS CITY, KS.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>LONNIE ROBERTS</b>	
13b. MOTHER'S MAIDEN NAME <b>ANNA MIMMS</b>		14. NAME OF HUSBAND OR WIFE <b>JOHNNIE B ROBERTS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES 3/20/43 to 9/22/43</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Johnnie Roberts 3711 E 21st. VA Hosp. Records. Kc, Mo.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Pulmonary Infarction, Lt. Lower Lobe</b>	
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		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 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. Attended the deceased from <b>6/28/63</b> to <b>6/30/63</b> and last saw him <sup>her</sup> alive on <b>6/30/63</b> Death occurred at <b>12:50 AM 6/30/63</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Norman K. Lee, MD</b>	
22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		22c. DATE SIGNED <b>6-30-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>7 3 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery Ft Leavenworth, Mo.</b>	23d. LOCATION (City, town, or county) <b>Leavenworth Kans</b>
24. FUNERAL DIRECTOR <b>C. K. Kerford Funeral Home K. C. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>7-2-63</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

USE BLACK INK OR TYPEWRITER RIBBON

8008

STATE OF OHIO

8008

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**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,

10-07

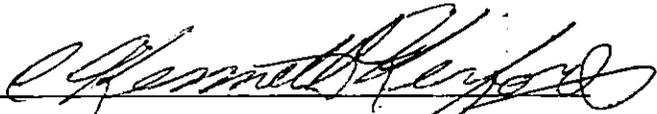
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4437

P. O. Address. [Handwritten]

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.