

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27747**
 BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 978

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) 70 yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2409 Oak St.		d. STREET ADDRESS (If rural, give location) 2409 Oak St.	

3. NAME OF DECEASED (Type or Print) a. (First) ROBERT b. (Middle) ANDREW c. (Last) BERTRAM			4. DATE OF DEATH (Month) (Day) (Year) August 31, 1953			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 8, 1874	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Month Days	IF UNDER 1 HRs. Hour Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Star Towel Supply		11. BIRTHPLACE (City and State or Foreign Country) Harrison County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Burl Bertram	13b. MOTHER'S MAIDEN NAME Martha Lewellen	14. NAME OF HUSBAND OR WIFE Ionia Bertram
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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. 495-26-0158	17. INFORMANT'S SIGNATURE OR NAME Mrs. R. A. Bertram	ADDRESS 2409 Oak St., City
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 mos.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Disease, Hypertensive		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension Arterial DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		443X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 3, 1953, to Aug 31, 1953, that I last saw the deceased alive on Aug 28, 1953, and that death occurred at 7:45A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>[Signature]</i>	23b. ADDRESS 207 Phys & Surg Bldg., City	23c. DATE SIGNED 9-1-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept 3, 1953	24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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DATE REC'D BY LOCAL REG. Sept 9, 1953	REGISTRAR'S SIGNATURE <i>[Signature]</i>	UNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS St. Joseph
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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, or by.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Eugene Wood

Licensed Embalmer No. *3804*

P. O. Address *319 S 10th St, Grand, 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 this body is not embalmed, fact should be so stated above.