

FILED AUG 21 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28958

BIRTH NO.		REG. DIST. NO. 146	PRIMARY REG. DIST. NO. 3026	Registrar's No. 325
1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY OR TOWN Independence	c. LENGTH OF STAY (In this place) 49 yrs	c. CITY (If outside corporate limits, write RURAL and give township) Independence (Blue)		
d. FULL NAME OF HOSPITAL OR INSTITUTION Indep. Sanitarium		d. STREET ADDRESS (If rural, give location) Rt 1 No River Road 11000		
3. NAME OF DECEASED (Type or Print)		a. (First) Roth	b. (Middle) D.	c. (Last) Bullard
4. DATE OF DEATH		4. DATE OF DEATH (Month) (Day) (Year) Aug 10, 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 8, 1864	9. AGE (In years, last birthday) 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) Burlington, Iowa	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Frederick Johnson		13b. MOTHER'S MAIDEN NAME Ursilla Brooks		14. NAME OF HUSBAND OR WIFE
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. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Ronald Bernichael	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. Cholelithiasis		INTERVAL BETWEEN ONSET AND DEATH 2 wks?
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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)	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 Aug 6, 1953, to Aug 10, 1953, that I last saw the deceased alive on Aug 10, 1953, and that death occurred at 11:30 a.m., from the causes and on the date stated above.				
23a. SIGNATURE Kenneth A. Mangels, M.D. (Degree or title)		23b. ADDRESS 129 W. Lexington		23c. DATE SIGNED 8/12/53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 8/12, 1953	24c. NAME OF CEMETERY OR CREMATORY Mount Grove Cem	24d. LOCATION (City, town, or county) (State) Indep. Mo	
DATE REC'D BY LOCAL REG. 8-12-53	REGISTRAR'S SIGNATURE James H. Kelly	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wilson L. Kelly Indep. Mo		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FACT

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 _____

William L. Keeley

Licensed Embalmer No. _____

4225

P. O. Address _____

Indep. mo

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.