

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31971

State File No. \_\_\_\_\_

FILED SEP 24 1953

4323

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

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 (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City

c. CITY OR TOWN Kansas City

d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION. General Hospital No. 1

e. STREET ADDRESS (If rural, give location) 7018 E. 12 Terr. 3218

3. NAME OF DECEASED  
a. (First) Jesse b. (Middle) A. c. (Last) Roan

4. DATE OF DEATH (Month) (Day) (Year) 9 1 1953

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH 5/5/03

9. AGE (In years last birthday) 50

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY -

11. BIRTHPLACE (City and State or Foreign Country) Union Co Iowa

12. CITIZEN OF WHAT COUNTRY? US

13a. FATHER'S NAME HENRY A. ROAN

13b. MOTHER'S MAIDEN NAME HARRIET McLaughlin

14. NAME OF HUSBAND OR WIFE Roan MARIE MILLES

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. 482-18-5961

17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mrs Marie Milles Roan K.C. Mo

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Pulmonary atelectasis left lung with cardiac arrest during surgery for neurogenic sarcoma and rt. lung pneumonectomy

ANTECEDENT CAUSES  
DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH  
193h

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES  NO

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) (Min.)

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 12, 1953, to Sept. 1, 1953, that I last saw the deceased alive on Sept. 1, 1953, and that death occurred at 10:05A m., from the causes and on the date stated above.

23a. SIGNATURE B.I. Burns (Degree or title)

23b. ADDRESS 24th & Cherry

23c. DATE SIGNED 9-2-53

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE 9/3/53

24c. NAME OF CEMETERY OR CREMATORY AFTON

24d. LOCATION (City, town, or county) (State) Afton Iowa

DATE REC'D BY LOCAL REG. 9-2-53

REGISTRAR'S SIGNATURE Sheldine Smith

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS SHELLES K.C. Mo

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

*An Embalmer*

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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.....  
Signature of Student Embalmer

Signed..... *J. P. Sheil*  
Licensed Embalmer No. *3625*

P. O. Address *K.C.M.O.*

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.