

FILED AUG 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27650

State File No.

3905

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>1002</u> | | Registrar's No. <u>3905</u> | |
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). | | | |
| a. COUNTY <u>Jackson</u> | | b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Missouri Kansas City</u>) | | c. LENGTH OF STAY (in this place) <u>30 yrs.</u> | | c. CITY OR TOWN <u>Kansas City</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pleasant View Home-4400 St. John,</u> | | | | STREET ADDRESS (If rural, give location) <u>5620 E 16th St.</u> | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or Print) | | a. (First) <u>VENA</u> | | b. (Middle) <u>S.</u> | | c. (Last) <u>ROBERTSON</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>8 9 54</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Managed-Apts.</u> | | 8. DATE OF BIRTH <u>Feb. 22, 1885</u> | | 9. AGE (In years last birthday) <u>69</u> | |
| 11a. BIRTHPLACE (City and State or Foreign Country) <u>Halleck, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 9. AGE (In years last birthday) <u>69</u> | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | |
| 11. BIRTHPLACE (City and State or Foreign Country) <u>Halleck, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> | |
| 13a. FATHER'S NAME <u>Dr. James K. Graham</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Robinson</u> | | 14. NAME OF HUSBAND OR WIFE <u>Ralph J. Robertson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Lucian L. Minor-5620 E 16th St.-K.C. Mo</u> | | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> | | ANTECEDENT CAUSES <u>Arterio sclerosis</u> | | | | <u>1 day</u> | |
| DUE TO (b) <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> | | DUE TO (c) | | | | <u>3 years</u> | |
| II. OTHER SIGNIFICANT CONDITIONS <u>4201</u> | | Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input 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) 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 <u>8-1-54</u> , 19 <u>54</u> , to <u>8-9-54</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>8-9-54</u> , 19 <u>54</u> , and that death occurred at _____ m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>Frank Paul Laurenciana MD</u> | | | | 23b. ADDRESS <u>498 S. White Ave</u> | | 23c. DATE SIGNED <u>8-9-54</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 24b. DATE <u>8/11/54</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Mora</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u> | |
| DATE REC'D BY LOCAL REG. <u>8-11-54</u> | | REGISTRAR'S SIGNATURE <u>Geraldine Smith</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Melody-McGilley-Eylar-Kansas City, Mo.</u> | | | |

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

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 *James E. Hackleman*

Licensed Embalmer No. *413*

P. O. Address *H. C. M.*

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.