

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

1954

State File No.

FILED MAY 18 1955

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 5227 Registrar's No. 54

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Rural Peculiar Twp.</u>)	c. LENGTH OF STAY (in this place) <u>2 Months</u>	c. CITY OR TOWN <u>Archie</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pleasant View Rest Home</u>		e. STREET ADDRESS (If rural, give location) <u>0190</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Rosetta</u>	b. (Middle) <u>Lavina</u>	c. (Last) <u>Heath</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 9 1955</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 11, 1865</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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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>Same</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Clark County, Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Robert Kizer</u>	13b. MOTHER'S MAIDEN NAME <u>Hannah Ann Buffenberger</u>	14. NAME OF HUSBAND OR WIFE <u>Amos W. Heath</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Lawrence Heath</u>	ADDRESS <u>Rt. 2 Sabula, Iowa</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>6 DAYS</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>BRONCHOPNEUMONIA</u>		DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>
	ANTECEDENT CAUSES 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. <u>INTERTRACHANTRIC FRACTURE RT FEMUR 4 WKS.</u>		DUE TO (c)	

19a. DATE OF OPERATION <u>MAY 9 1955</u>	19b. MAJOR FINDINGS OF OPERATION <u>4500 F</u>	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from MAR. 15, 1955, to MAY 9, 1955, that I last saw the deceased alive on MAY 9, 1955, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

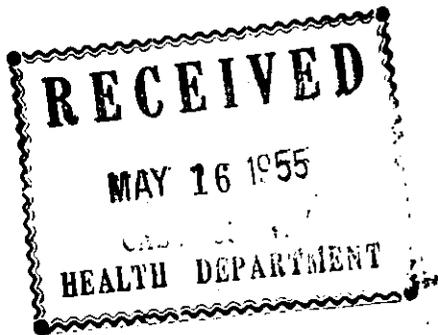
23a. SIGNATURE (Deceased or title) <u>Leslie C. Moody M.D.</u>	23b. ADDRESS <u>HARRISONVILLE MO.</u>	23c. DATE SIGNED <u>5-11-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5/12/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crescent Hill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Adrain, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>May 11, 1955</u>	REGISTRAR'S SIGNATURE <u>Dora Barnard</u>	457-10	25. FUNERAL DIRECTOR'S SIGNATURE <u>William Ross Hancock, mo.</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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 *Robert W. Atkinson*

Licensed Embalmer No. *490*

P. O. Address *Harrisonville*

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.