

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms must be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Herbert T. Ravines

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38212

STATE FILE NUMBER

FILED NOV 28 1956

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4931

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>KANSAS</b> b. COUNTY <b>Sabette</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ERIE</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V.A. HOSPITAL</b>		Length of stay in lb <b>2 days</b>	d. STREET ADDRESS (If outside, give location) <b>General Delivery</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>CHARLES</b> Last <b>ROBERTSHAW</b>			4. DATE OF DEATH Month <b>11th</b> Day <b>13th</b> Year <b>1956</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-23-91</b>	9. AGE (In years last birthday) <b>65 yrs</b> IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (City and state or country) <b>Lincoln, Nebraska</b>	
13. FATHER'S NAME <b>Charles Robertshaw</b>			14. MOTHER'S MAIDEN NAME <b>Laura Haas</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 12-12-12 to 8-3-29</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>VA Hospital Records, K.C., MO.</b> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured aneurysm of the abdominal aorta</b>					INTERVAL BETWEEN ONSET AND DEATH <b>45 hr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. attended the deceased from <b>November 11, 1953 to November 13, 1956</b> Death occurred at <b>1:50pm</b> <input checked="" type="checkbox"/> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Herbert T Ravines M.D.</b>			22b. ADDRESS <b>V.A. Hospital, Kansas City, Mo</b>		22c. DATE SIGNED <b>11-13-56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Nov. 15, 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>—</b>		23d. LOCATION (City, town, or county) (State) <b>ERIE KANSAS</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS, KANSAS City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-14-56</b>		26. REGISTRAR'S SIGNATURE <b>Neve Minshall</b>	

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 Ray*.....

Licensed Embalmer No. *412*

P. O. Address *K. City*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.