

FILED MAY 7-1957

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

13377

1826

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

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hickman Mills,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u>				Length of stay in 1b <u>1 day</u>	700 ⁰ d. STREET ADDRESS <u>11312 Grandview Road</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Raymond</u> Last <u>Roach</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1957</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-4-43</u>	9. AGE (In years last birthday) <u>13</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	11. BIRTHPLACE (City and state or country) <u>Jackson Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Raymond Roach</u>				14. MOTHER'S MAIDEN NAME <u>Alice Reed</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Alice E Roach</u> <u>Indep., Mo.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>subacute glomerulonephritis with acute exacerbaton</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral edema; massive pulmonary edema</u> DUE TO (c) <u>Myocardial hypertrophy, Left. HYPERTENSION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>4434</u>
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 WORK <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. I attended the deceased from <u>4-14-57</u> to <u>4-15-57</u> and last saw <u>her</u> alive on <u>4-15-57</u> Death occurred at _____ A _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>H. L. Ketterman M.D.</u> (Degree or title) <u>D</u>				22b. ADDRESS <u>Hickman Mills, Mo</u>		22c. DATE SIGNED <u>4-17-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Apr. 18, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Independence, Mo.</u>				
24. FUNERAL DIRECTOR <u>Geo. C. CARSON</u> <u>Indep. Mo</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4-18-57</u>		26. REGISTRAR'S SIGNATURE <u>neva minshall</u>				

(Licensed Embolmer's Statement on Reverse Side)

Health,
& Welfare
Public
Service300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 H. L. Ketterman



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. H. Gibson

Licensed Embalmer No. *487*

P. O. Address *Indep. Mo.*

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