

FILED NOV 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36099
STATE FILE NUMBER
4819

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

300

1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Elias E. Zirul

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HAWKERS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MO KANSAS CITY</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>Lakeside Hosp</u> Length of stay in lb <u>unk.</u>		d. STREET ADDRESS (If outside, give location) <u>6055 Sweepartway</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Dine</u> Last <u>Roberts</u>			4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>57</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W. at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Surgeon, Boone Co, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>Thomas Kanatzar</u>		13b. MOTHER'S MAIDEN NAME <u>Toy Brakehill</u>	14. NAME OF HUSBAND OR WIFE <u>William Frank Roberts</u>
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>-</u>	17. INFORMANT Address <u>R.F. Roberts 60-6055 Sweepartway</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>Acute Congestive Heart Failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4437</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24h.</u> <u>10 yrs</u> <u>30 yrs</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 <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>9-11-57</u> to <u>10-17-57</u> and last saw her/him alive on <u>10-17-57</u> Death occurred at <u>12:55 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Elias E. Zirul D.O.</u> (Degree or title)		22b. ADDRESS <u>4640 Troost Ave</u>	22c. DATE SIGNED <u>10/17/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-17-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chapel Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Randolph Co., Mo.</u>
24. FUNERAL DIRECTOR <u>Melody McGilley - Eylan - K.C. Mo</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-18-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>

Sp 11-8-00

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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 *James E. Hackler*

Licensed Embalmer No. *4573*

P. O. Address *K C Mo.*

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.