

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 29 1958

1544
STATE FILE NUMBER 31

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 31

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		c. CITY OR TOWN Buckner	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Crestview Rest Home		d. STREET ADDRESS (If outside, give location) 1000	
3. NAME OF DECEASED (Type or print) First Katie Middle Roedel Last Roedel		4. DATE OF DEATH Month Jan. Day 23 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) Indiana
13a. FATHER'S NAME Godffried Roedel		13b. MOTHER'S MAIDEN NAME Elizabeth Pfiesser	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Mrs. Anna Drewel Buckner, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver 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)			INTERVAL BETWEEN ONSET AND DEATH 6 mo
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 11/27/57 to 1/23/58 and last saw ^{her} alive on 1/17/58 Death occurred at 7:45p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. G. Grabske & Sons, M.D.		22b. ADDRESS 10901 Winner Rd Independence, Mo	22c. DATE SIGNED 1/28/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan. 24, 1958	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Wellington, Missouri
24. FUNERAL DIRECTOR Geo. C. Carson & Sons Independence, Mo	25. DATE RECD. BY LOCAL REG. 1-24-58	26. REGISTRAR'S SIGNATURE [Signature]	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *W. Gibson*

Licensed Embalmer No. *4871*

P. O. Address: *Indep 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.