ot. Health,
, & Welfare
S. Public
lth Service

S. 300
v. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-036730
STATE FILE NUMBER

FILED NOV 12 1958 Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 459

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. San. & Hosp. — Length of stay in Ib 71 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Independence 7005 0 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) Rest Haven Home — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First EDITH Middle DRUCILLA Last BAILEY ROBERTS
4. DATE OF DEATH Month Oct. Day 31, Year 1958
5. SEX Female 1
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH March 3, 1887
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (City and state or country) Independence, Mo. c
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Geo. Marion Bailey
13b. MOTHER'S MAIDEN NAME Eva Alice Cameron
14. NAME OF HUSBAND OR WIFE Willie L. Roberts, Dec'd/
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Myron Roberts, Address 3007 So. Sterling, Indep., Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage from (benign) polyps of colon — INTERVAL BETWEEN ONSET AND DEATH 2 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 211X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized rheumatoid arthritis
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 1952, to 10-31-58 and last saw her alive on 10/30/58
Death occurred at 555 h m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Drs. Grabske & Link (Degree or title) Vance E. Link, MD
22b. ADDRESS 10901 Winner, Indep., Mo.
22c. DATE SIGNED 10-31-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 11-3-58
23c. NAME OF CEMETERY OR CREMATORY Md. Grove Cemetery
23d. LOCATION (City, town, or county) Independence, (State) Missouri

24. FUNERAL DIRECTOR Geo. C. Carson & Sons, ADDRESS Indep., Mo.
25. DATE RECD. BY LOCAL REG. 11-3-58
26. REGISTRAR'S SIGNATURE [signature]

(Licensed Embalmer's Statement on Reverse Side)

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 C. Ray Lauderback

Licensed Embalmer No. 5027

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.