Health, Welfare Public Service

300 -57 4

FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005843
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 863

1. PLACE OF DEATH a. COUNTY Jackson	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas City b. COUNTY Johnson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN Leawood 9150 8 — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Cresthaven N. Home 3516 Summitt — Length of stay in lb 4 yrs	d. STREET ADDRESS (If outside, give location) 9310 Chadwick — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Newtie	Middle V.	Last Robertson	4. DATE OF DEATH Month Feb.	Day 13, Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH Oct, 22, 1879	9. AGE (In years last birthday) 79 — 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	11. BIRTHPLACE (City and state or country) Baxter County Arkansas	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Newton Wiley	13b. MOTHER'S MAIDEN NAME Nannie Walker	14. NAME OF HUSBAND OR WIFE James David Robertson		
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 Leon Robertson Address 9310 Chadwick		

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) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 3 da

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic cerebro vascular disease — 10 yrs +

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 ☐ 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 Sept 52, to 2-13-59 and last saw her/him alive on 2-12-59
Death occurred at 12 40 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) E L Petry MD.	22b. ADDRESS 701 E 63d St. Kansas City Mo	22c. DATE SIGNED 2-13-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/15/59	23c. NAME OF CEMETERY OR CREMATORY Gassville Cemetery
23d. LOCATION (City, town, or county) Gassville (State) Arkinsas		
24. FUNERAL DIRECTOR ADDRESS Stine & McClure K. C. Mo.	25. DATE RECD. BY LOCAL REG. 2-14-59	26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

E. L. Petry

N. 4-080

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 Elmer Triplett

Licensed Embalmer No. 4817

P. O. Address R. L. Wo.

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.