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THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-006013

FILED MAR 10 1959 Registration District No. 146 Primary Registration District No. 3026 STATE FILE NUMBER Registrar's No. 108

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If inside corporate limits, give TOWNSHIP only) OR TOWN Independence — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 9853 Wornall — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Independence — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 9517 E. 13th (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Blanche Middle M. Last Roberts
4. DATE OF DEATH Month Mar. Day 5 Year 1959
5. SEX Female
6. COLOR OR RACE Wht
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Oct 26, 1881
9. AGE (In years last birthday) 77 — 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) Home Maker
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (City and state or country) Madison Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John West
13b. MOTHER'S MAIDEN NAME Sadie Standard
14. NAME OF HUSBAND OR WIFE William W. Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give the dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Lenore Lefler Address 9853 Wornall Independence

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) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) with Cardiac Decompensation
DUE TO (c) Generalized arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Cholecystitis 4200
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 1951, to present and last saw her alive on 3/4/59
Death occurred at 9:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C B Holton, MD (Degree or title)
22b. ADDRESS Independence Mo
22c. DATE SIGNED 3/6/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Mar 7/59
23c. NAME OF CEMETERY OR CREMATORY Highland Cem.
23d. LOCATION (City, town, or county) (State) Ottawa Kansas

24. FUNERAL DIRECTOR Roland R. Speaks ADDRESS
25. DATE RECD. BY LOCAL REG. 3-7-59
26. REGISTRAR'S SIGNATURE Thomas B. Grace

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Rollie Tessel

Licensed Embalmer No. 4690

P. O. Address Indep. Mo.

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