

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009637  
STATE FILE NUMBER  
1389

FILED APR 2 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1389

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>601 E. 73rd.</b>		Length of stay in lb <b>unk.</b>	d. STREET ADDRESS (If outside, give location) <b>601 E. 73 rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Heber</b> Middle <b>E</b> Last <b>Roney</b>			4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1890</b>
9. AGE (In years last birthday) <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banker</b>	11. BIRTHPLACE (City and state or country) <b>Detroit, Michigan</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13a. FATHER'S NAME <b>John Harvey Roney</b>	13b. MOTHER'S MAIDEN NAME <b>Phila McMichen</b>
14. NAME OF HUSBAND OR WIFE <b>Katherine E. Roney</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>486-01-0199</b>
17. INFORMANT <b>Mrs. Katherine E. Roney</b>		Address <b>601 E. 73, K.C. Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation - Terminal</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Acute Myocardial Infarction -</b>			<b>4 hours</b>
DUE TO (c) <b>Coronary Artery Sclerosis + Occlusion</b>			<b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>42</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>_____</b>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>_____</b>	20f. CITY, TOWN, OR LOCATION <b>_____</b>	COUNTY <b>_____</b>	STATE <b>_____</b>
21. I attended the deceased from <b>December 1950 to March 13, 1959</b> and last saw <sup>her</sup> alive on <b>March 13, 1959</b> . Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Graham Asher M.D.</b>		22b. ADDRESS <b>1220 Professor Blvd - Kansas City 6 - Mo</b>	22c. DATE SIGNED <b>3-13-1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Mar. 16, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
24. FUNERAL DIRECTOR <b>Geo. C. Carson &amp; Sons</b>		ADDRESS <b>Indep. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-16-59</b>
26. REGISTRAR'S SIGNATURE <b>Nevas Minshall</b>			

300

BY AFFIDAVIT OF Physician  
6-4-59

USE ONLY BLACK INK OR RIBBON TYPE-WRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.  
Graham Asher

OCT 20 1959

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 *Elean W. Huff* .....

Licensed Embalmer No. *4914* .....

P. O. Address *Indy, 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.