

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-022374

FILED JUN 29 1959

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 218

STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Pettis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Length of stay in 1b <u>60 yrs</u>		c. CITY OR TOWN <u>Sedalia</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>519 West 4th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>EUGENIA</u>		Middle <u>C.</u>		Last <u>ROBERTSON</u>		Month <u>June</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1881</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>Robert S. Robertson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Dr. R. C. Williamson</u> Address <u>Sedalia</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Arteriosclerotic C-V disease</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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) <u>Malnutrition</u>					PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	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 _____ a.m. _____ p.m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>5 June 1959</u> to <u>25 June 1959</u> and last saw her <u>alive</u> on <u>25 June 1959</u> . Death occurred at <u>4:36 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>R. S. Siegel MD</u> (Degree or title)				22b. ADDRESS <u>Smithton Mo</u>		22c. DATE SIGNED <u>6/25/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>6-21-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		23d. LOCATION (City, town, or county) <u>Sedalia</u>		(State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>McLaughlin Bros</u> ADDRESS <u>Sedalia</u>			25. DATE RECD. BY LOCAL REG. <u>6-26-1959</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 23 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
or by Harold Tempel Student Embalmer No. 800

working under my personal supervision.

Student Harold Tempel
Signature of Student Embalmer

Signed K. P. McClarrar

Licensed Embalmer No. 3153
P. O. Address Sedalia 7

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.