

DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-029287

FILED VS SEP 14 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4202

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in 1b <u>2 weeks</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> c. CITY OR TOWN <u>Independence</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>9508 E. 13th</u>			
3. NAME OF DECEASED (Type or print) First <u>GUY</u> Middle <u>WHITE</u> Last <u>ROBERTS</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>27</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/94</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Allis Chalmers</u>		11. BIRTHPLACE (City and state or country) <u>Boone Co., Mo.</u>			
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>James W. Roberts</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Leona Baber</u>			
14. NAME OF HUSBAND OR WIFE <u>Olive W. Roberts</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWT</u>		16. SOCIAL SECURITY NO. <u>495-03-4689</u>			
17. INFORMANT <u>Mrs. Olive W. Roberts</u>		Address <u>9508 E. 13th</u>		City <u>Indep., Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</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) _____ 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					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 checked="" 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>August 15 1959</u> ¹⁰ and last saw <u>him</u> alive on <u>Aug. 27, 1959</u> Death occurred at <u>1:00</u> <u>P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Albert I. Decker</u> (Degree or title)			22b. ADDRESS <u>Kansas City, Mo.</u>		22c. DATE SIGNED <u>8-28-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 29, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington cemetery</u>		23d. LOCATION (City, town, or county) <u>Kansas City, Missouri</u> (State)		
24. FUNERAL DIRECTOR <u>Geo. C. Carson & Sons</u>			ADDRESS <u>Indep., Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-28-59</u>		
26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>							

DOCUMENT

MEDICAL CERTIFICATION

 BY AFFIDAVIT OF Albert I. Decker

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 _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Raymond F. Stema

Licensed Embalmer No. 426
P. O. Address Independence

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.