

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS SEP 15 1959

59-029440

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 390

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Independence		Length of stay in lb OR TOWN 2 days	c. CITY OR TOWN Independence Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. Sanit. & Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1835 S. Noland Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First CARROLL Middle MAXINE Last YEAGER			4. DATE OF DEATH Month September Day 6 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/16/36	9. AGE (last birthday) 22	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Crown Drug Co.	11. BIRTHPLACE (City and state or country) Independence, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Ernest L. Robinson		13b. MOTHER'S MAIDEN NAME Susana Bowman		14. NAME OF HUSBAND OR WIFE Robert R. Yeager		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 497-36-4101	17. INFORMANT Mr. Robert R. Yeager Address 1835 S. Noland Independence, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock + Amarrriage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pushed over for bus DUE TO (c) Contracture hand		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Operation at Ind Sanitarium		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 checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) I was car collision
20c. TIME OF INJURY Hour 8:45 Month, Day, Year 9-9-59 s.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. CITY, TOWN, OR LOCATION Independence	COUNTY Jackson	STATE Mo
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) James A. Carson		22b. ADDRESS 1034 Realty Bldg	22c. DATE SIGNED 9-8-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/9/59	23c. NAME OF CEMETERY OR CREMATORY Oak Ridge Memory Gardens	23d. LOCATION (City, town, or county) (State) Independence, Missouri
24. FUNERAL DIRECTOR Geo. C. Carson & Sons	ADDRESS Indep., Mo.	25. DATE RECD. BY LOCAL REG. 9-9-59	26. REGISTRAR'S SIGNATURE James A. Carson

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

65618 F NOV 23

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 Dean W. Huff

Licensed Embalmer No. 4914
P. O. Address Indy, Ma.

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.