

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039386

FILED VS DEC 9 1959

Registration District No. 5291 Registrar's No. 135

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY CLAY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CLAY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LIBERTY		Length of stay in 1b 15 WKS.	c. CITY OR TOWN EXCELSIOR SPRINGS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION I.O.O.F. HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 337 E. EXCELSIOR		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT FRANKLIN JAMES			4. DATE OF DEATH Month Day Year Nov. 18, 1959		
5. SEX MALE	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 2-6-1877	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) NASHVILLE, TENN.		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME FRANK JAMES		13b. MOTHER'S MAIDEN NAME ANN RALSTON		14. NAME OF HUSBAND OR WIFE MAE A. JAMES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES SP-AMERICAN		16. SOCIAL SECURITY NO. NONE	17. INFORMANT MAE A. JAMES, 337 E. EXCELSIOR EX. SPRINGS, MO.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse					INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic cardiac disease					10 yrs
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	
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 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 Sept 59 to 18 Nov 59 and last saw her/him alive on 17 Nov 59 Death occurred at 7:10 PM m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) J.M. Waterman, MD			22b. ADDRESS Liberty, Mo		22c. DATE SIGNED 1 Dec 59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED	23b. DATE 11-18-59	23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW		23d. LOCATION (City, town, or county) (State) KEARNEY, MO.	
24. FUNERAL DIRECTOR Prichard Funeral Home, Inc. Excelsior Springs, Missouri		25. DATE RECD. BY LOCAL REG. 12-4-59	26. REGISTRAR'S SIGNATURE Mabel Graham		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 4 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 Lindell Jarman

Licensed Embalmer No. 4589
P. O. Address Excelsior Springs

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.