

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. AUG 15 1960 393

=60-026220

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 3922 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY, Mo.</u>		Length of stay in 1b <u>LIFE</u>	c. CITY OR TOWN <u>KANSAS CITY, NORTH</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4341 MILAN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4341 MILAN</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSELLA MELTON</u>			4. DATE OF DEATH Month Day Year <u>JULY 28, 1960</u>			
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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>JUNE 15, 1977</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>CLAY COUNTY, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JAMES T. BLACKBURN</u>	13b. MOTHER'S MAIDEN NAME <u>MARY C. WISINAND</u>	14. NAME OF HUSBAND OR WIFE <u>EMERY B. MELTON</u>
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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>500-28-6029</u>	17. INFORMANT <u>MRS. CATHERINE BARKLEY</u> Address <u>4341 MILAN K.C. 16, Mo.</u>
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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) <u>Stroke (cerebral thrombosis)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>(plaque)</u>	
	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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour a.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
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21. I attended the deceased from June 1, 1958 to 7-28-60 and last saw her/him alive on 7-28-60
Death occurred at 12:35 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Charles H. Smith M.D.</u> (Degree or title)	22b. ADDRESS <u>4130 N. Main Rd. H.C. 17 Mo.</u>	22c. DATE SIGNED <u>7-28-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-30-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EAST SLOPE CEMETERY</u>	23d. LOCATION (City, town, or county) <u>RIVERSIDE, Mo.</u>
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24. FUNERAL DIRECTOR <u>D.W. NEWCOMERS SONS N.K.C., Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>7-30-60</u>	26. REGISTRAR'S SIGNATURE <u>H.L. Dwyer</u> m. d.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF Charles H. Smith

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 John H. Halsebeck
Licensed Embalmer No. 4-949
P. O. Address Mo. Kansas

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.