

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001988

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 382

STATE FILE NUMBER

AMENDED

FILED FEB 6 1962

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in 1b 40 YEARS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 10619 Hillcrest Road Inside Limits Yes No
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 10619 Hillcrest Road Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
SAMUEL THOMAS ROSSEAN, JR. January 20 1962

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 12/23/81 9. AGE (last birthday) 80
IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) Fremont Co, Iowa 12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME Samuel T. Rossean, Sr. 13b. MOTHER'S MAIDEN NAME Luraney 14. NAME OF HUSBAND OR WIFE Catherine Rossean

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. 17. INFORMANT Address Catherine Rossean, 10619 Hillcrest Rd.

18. CAUSE OF DEATH (Enter only one cause per line if PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction Acute 2 days
DUE TO (b) Arteriosclerosis General
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year
a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 Feb 61 to Jan 20 62 and last saw her alive on Jan 20 62
Death occurred at 2:00 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. D. Bennett M.D. 22b. ADDRESS 499 E 63rd N.C Mo 22c. DATE SIGNED 1/21/62

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 23b. DATE JAN. 23, 1962 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVE CEMETERY 23d. LOCATION (City, town, or county) (State) HAMBURG IOWA

24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo. ADDRESS 1331 Brush Creek Blvd. 25. DATE RECD. BY LOCAL REG. 1-22-62 26. REGISTRAR'S SIGNATURE Ruth Long

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Vern Lawler

Licensed Embalmer No. 4915

P. O. Address 1670

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.