

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-027467

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 379

FILED AUG 14 1962	
1. PLACE OF DEATH	
a. COUNTY JACKSON	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN INDEPENDENCE	a. STATE MISSOURI b. COUNTY JACKSON
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION JEWELL NURSING HOME	c. CITY OR TOWN INDEPENDENCE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. STREET ADDRESS 10804 E. 19th Street	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH
First JAMES Middle WORLEN Last ROBERTS	Month AUGUST Day 9 , Year 1962
5. SEX MALE	6. COLOR OR RACE WHITE
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1866
9. AGE (last birthday) 95	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARMING
11. BIRTHPLACE (City and state or country) BOONE COUNTY, MISSOURI	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME ABRAM ROBERTS	13b. MOTHER'S MAIDEN NAME MARTHA BALLEW
14. NAME OF HUSBAND OR WIFE NANCY LEONA ROBERTS-Dec'd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NONE
17. INFORMANT Stephen M. Roberts, 10804 E. 19th St., INdep.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) myocardial failure	INTERVAL BETWEEN ONSET AND DEATH 12 hrs
DUE TO (b) pulmonary edema	24 hrs
DUE TO (c) atherosclerosis + old age	30 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) old age - myocardial insufficiency	
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 Nov 1961 , to Aug 8, 1962 and last saw him alive on Aug 8, 1962	
Death occurred at 9:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) W^m F. Knecht A.B.D.D.	22b. ADDRESS 11109 Winnie Rd.
22c. DATE SIGNED 8-10-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8-12-62
23c. NAME OF CEMETERY OR CREMATORY CENTRALIA CEMETERY	23d. LOCATION (City, town, or county) (State) CENTRALIA, MISSOURI
24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO.	25. DATE RECD. BY LOCAL REG. 8-11-62
26. REGISTRAR'S SIGNATURE Alba L. Craig	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59
17005
27005
3
4 0
5 2
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7 0
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9422.1
10
11
12 86-2
13 1-0

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 Marshall C. Bluewell

Licensed Embalmer No. 4713

P. O. Address Raytown, Mo.

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.