

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-041928

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 195

FILED DEC 4 1962

VS 300
Rev. 4/59

10190
27005

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11 019
12 71-3
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH - a. COUNTY CASS		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) Big CREEK Twp.		Length of stay in 1b _____	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) Highway U.S. 71 Bypass		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2505 1/2 Vermont Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ROBERT ALLEN DISNEY		4. DATE OF DEATH November 25 - 1962	
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 2/8/1938
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office manager		10b. KIND OF BUSINESS OR INDUSTRY Finance	9. AGE (last birthday) 29 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
13a. FATHER'S NAME Rolla Disney		13b. MOTHER'S MAIDEN NAME Mildred Minks	14. NAME OF HUSBAND OR WIFE Betty Ray Disney
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Mrs. Betty Disney Address 2505 1/2 Vermont Independence, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for Part I. Death was caused by: PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal Hemorrhage of Chest Cavity DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Instant
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 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.) Car accident	
20c. TIME OF INJURY 4:30 a.m. 11-25-62			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 8 mi north of on 71 Bypass	20f. CITY, TOWN, OR LOCATION Harrisonville COUNTY Cass STATE MO.
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Sherrill Cummings		22b. ADDRESS Cass Co Courthouse Harrisonville Mo	22c. DATE SIGNED 11-26-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-26-1962	23c. NAME OF CEMETERY OR CREMATORY OSCEOLA Cemetery	23d. LOCATION (City, town, or county) (State) OSCEOLA, Missouri
24. FUNERAL DIRECTOR Goodrich Funeral Home, OSCEOLA, MO.		25. DATE RECD. BY LOCAL REG. 11-26-62	26. REGISTRAR'S SIGNATURE Robert J. DeBree

12-4-62

DEC 27 1962

OCT 2 1962

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 Robert W. Williams

Licensed Embalmer No. 4902

P. O. Address Hammond, 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.