

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-047550

STATE FILE NUMBER

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 127

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 3 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Lawrence</b></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>AURORA</b> Length of stay in 1b <b>YEARS</b></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>122 E. PLEASANT</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <b>MO.</b> b. COUNTY <b>LAWRENCE</b></p> <p>c. CITY OR TOWN <b>AURORA</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <b>122 E. PLEASANT</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First Middle Last <b>CATHERINE ROSELLA BROWN</b></p>	
<p>4. DATE OF DEATH Month Day Year <b>Dec. 27, 1962</b></p>	
<p>5. SEX <b>FEMALE</b></p>	<p>6. COLOR OR RACE <b>WHITE</b></p>
<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>4/25/70</b></p>
<p>9. AGE (last birthday) <b>92</b></p>	<p>IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b></p>
<p>11. BIRTHPLACE (City and state or country) <b>LAWRENCE CO., MO.</b></p>	<p>12. CITIZEN OF WHAT COUNTRY <b>USA</b></p>
<p>13a. FATHER'S NAME <b>THOMAS D. ROBERTSON</b></p>	<p>13b. MOTHER'S MAIDEN NAME <b>SOPHIA MONTGOMERY</b></p>
<p>14. NAME OF HUSBAND OR WIFE <b>*****</b></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b></p>	<p>16. SOCIAL SECURITY NO. <b>NONE</b></p>
<p>17. INFORMANT <b>TROY BURNEY:</b> Address <b>AURORA, MO.</b></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>Hemorrhage, Cerebral, Massive</b></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension, Essential</b></p> <p>DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p>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</p> <p>INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b></p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>	
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <b>Dec. 27, 1962</b> to <b>Dec. 27, 1962</b> and last saw her alive on <b>Dec. 27, 1962</b></p> <p>Death occurred at <b>10:30 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <b>Janet L. Kelsey, M.D.</b></p>	<p>22b. ADDRESS <b>Aurora, Mo</b></p>
<p>22c. DATE SIGNED <b>12/20/62</b></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>	<p>23b. DATE <b>12/29/62</b></p>
<p>23c. NAME OF CEMETERY OR CREMATORY <b>MAPLE PARK CEMETERY</b></p>	<p>23d. LOCATION (City, town, or county) (State) <b>AURORA, MO.</b></p>
<p>24. FUNERAL DIRECTOR ADDRESS <b>ARNOLD'S FUNERAL HOME: AURORA, MO.</b></p>	<p>25. DATE RECD. BY LOCAL REG. <b>12-30-62</b></p>
<p>26. REGISTRAR'S SIGNATURE <b>Georgio L. Ungley</b></p>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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 James D. Crafton

Licensed Embalmer No. 4668

P. O. Address Aurora, 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.