

JAN 15 1940
Registration District No. 701

Primary Registration District No. 51980

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Polk Missouri
(b) City or town Rural
(c) Name of hospital or institution: Marion Township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME ROY CARL ROBERTS. 163

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec - 20 - 39
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Polk County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Roy Roberts

13. Birthplace Adonis Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Grace Wilson

15. Birthplace Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Roy Roberts

(b) Address Adonis Mo

17. (a) Inter (b) Date thereof Dec 20 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Adonis Mo

18. (a) Signature of funeral director Hutchison - Blue

(b) Address Adonis Mo

19. (a) J. Roberts (b) J. Roberts
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Polk
(c) City or town Adonis Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20 year 1939 hour 1-1 minute 6⁰⁰ P. M.

21. I hereby certify that I attended the deceased from Dec. 20 1939, to Dec. 20 1939.
that I last saw him alive on Dec. 20 1939.
and that death occurred on the date and hour stated above.

Immediate cause of death Pre-mature - 7 Months - malnutrition
Due to (Post-natal) (Cause)
Due to _____

Other conditions (include pregnancy within 3 months of death) 154

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. D. Smith (M. D. or other) _____
Address Adonis Mo Date signed _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.