

Registration District No. **312**

Primary Registration District No. **5431A**

Registrar's No. \_\_\_\_\_

**I. PLACE OF DEATH:**

(a) County **Gentry**  
(b) City or town **Rural - Jackson Twp**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **since 1926** years, months or days (Specify whether)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **mo** (b) County **Gentry**  
(c) City or town **rural** (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **March** day **6** - **40**  
year \_\_\_\_\_ hour **4:40** minute **2** M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1938, to **March 6**, 1940, that I last saw h<sup>e</sup> alive on **March 1**, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death **Mural Thrombosis** Duration **sudden**

Due to **Myocarditis** **3 yrs.**

Due to \_\_\_\_\_

Other conditions **Arthritis Rheumatica** **4 yrs.**  
(Include pregnancy within 3 months of death)

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) **no**  
(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? **no**

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

23. Signature **Frank H. Rose** (M. D. or other) **MD.**  
Address **Albany mo** Date signed **3-7-40**

8. (a) PRINT FULL NAME **Nellie Rachel Roberts**

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **Wh**  
6. (a) Single, widowed, married, divorced **Divorced**

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

7. Birth date of deceased **2 11 1883**  
(Month) (Day) (Year)

8. AGE: Years **57** Months **0** Days **25** If less than one day hr. \_\_\_\_\_ min.

9. Birthplace: **Gentry County** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name: **George W. Smith**  
13. Birthplace: **Deerfoot Ill.** (City, town, or county) (State or foreign country)  
14. Maiden name: **Melinda Ward**  
15. Birthplace: **Deerfoot Ill.** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Wm Hogeremans**  
(b) Address **3029 Grand Ave Kansas City Mo.**

17. (a) **Burial** (b) Date thereof **3 8 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lafayette Cemetery**

18. (a) Signature of funeral director **J. Edgar Johnson**  
(b) Address **214 S. 1st St. Mo.**

19. (a) **Mar 7-40** (b) **Douglas D. Smith**  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED FILED STATE OFFICE  
INDEX CARD RETURNED TO DISTRICT  
DATE MAR 10 1930

**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 J. Evan Johnson

Licensed Embalmer No. 3492

P. O. Address Sturbridge Mass

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **6596**  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **312**

Primary Registration District No. **5431a**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Generty**  
(b) City or town **Jackson Two**  
(c) Name of hospital or institution:  
(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

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

**Nellie Rachel Roberts**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **7** 5. Color or race **w**  
6. (a) Single, widowed, married, divorced **Div**  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **37** Months **0** Days **25-**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **Mar 9 40** (b) **Donald S. Gault**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month **Mar** day **6**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 **Frank N. Rowan**

Address **Altany Mo** Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

