FILED MAR 7 - 1940

S. No. 2
—11-10-39
v. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

6865

State File No.

Registration District No. 398 Primary Registration District No. 5-5-5-4 3019 Registrar's No. 54

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: At Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether

In this community years, months or days) 1 or 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Independence (If outside city or town limits, write "RURAL")

(d) Street No. 1623 S. Spring (If rural, give location)

(e) If foreign born, how long in U. S. A.? ——— years.

3. (a) PRINT FULL NAME Harriet Charline Roberts

3. (b) If veteran, name war ———

3. (c) Social Security No. 496-01-8527

4. Sex Female

5. Color or race Wh

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joseph A. Roberts

6. (c) Age of husband or wife if alive ——— years

7. Birth date of deceased Aug. 7 (Month) (Day) 1910 (Year)

8. AGE: Years 29 Months 6 Days 9 If less than one day ——— hr. ——— min.

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

10. Usual occupation House Wife at home

11. Industry or business

FATHER
12. Name Joseph B. Witt
13. Birthplace Red Sulphur Sps. (City, town, or county) West Virg. (State or foreign country)

MOTHER
14. Maiden name Mary A. Harris
15. Birthplace Buckner (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Joseph A. Roberts

(b) Address 1623 S. Spring Indep. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18-40 (Month) (Day) (Year)

(c) Place: burial or cremation Buckner Cemetery

18. (a) Signature of funeral director Ott + Mitchell

(b) Address Independence Mo

19. (a) Feb 17-1940 (Date received local registrar) (b) F. L. Cook 360 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16 year 1940 hour 11 minute 30 A M.

21. I hereby certify that I attended the deceased from Jan 22, 1940, to 2-16-, 1940; that I last saw her alive on 2-16-, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Thrombosis of cerebral artery	
Due to Hypotension and Anaemia	
Due to Gastro-intestinal Neurosis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations no operation

Of autopsy no autopsy — Autopsy was refused

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature C. H. Allen (M. D. or other) M.D.

Address Independence Mo Date signed 2-17-40

(Licensed Embalmer's Statement on Reverse Side)

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.