No. 2
-11-10-39
5-17-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 14 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8333

Registration District No. 560 | Primary Registration District No. 6094 | Registrar's No. 2

1. PLACE OF DEATH:

(a) County ~~Shelby~~ Shelby

(b) ~~City or town~~ Jefferson ~~Cole~~ Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: [illegible]
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby

(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 Augusta Lee Roberts.

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

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

6. (b) Name of husband or ~~wife~~ John Roberts 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased July (Month) 28 (Day) 1861 (Year)

8. AGE: Years 78 Months 6 Days 14 If less than one day ____ hr. ____ min.

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

10. Usual occupation House wife

11. Industry or business ____

FATHER
12. Name Monroe Milliard
13. Birthplace ____ (City, town, or county) K.Y. (State or foreign country)

MOTHER
14. Maiden name Martha Greenings
15. Birthplace ____ (City, town, or county) Mo. (State or foreign country)

16. (a) Informant John Roberts
(b) Address Clarence Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-40 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Shelbina Mo

18. (a) Signature of funeral director E. E. Hopson
(b) Address Clarence Mo.

19. (a) Mch 8-1940 (Date received local registrar) (b) Roy Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12 1940
year 1940 hour 10 a.m. minute ____ M.

21. I hereby certify that I attended the deceased from May 1930 ____, 19__ to Feb 12 1940, 19__;
that I last saw her alive on Feb 11 1940, 19__;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Intestinal tuberculosis	20 yrs
Due to ____	
Due to ____	
Other conditions Trachoma (Include pregnancy within 3 months of death)	50 yrs

Major findings: Of operations none recently
Intestinal tuberculosis found at operation 20 yrs ago
Of autopsy no

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 no
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no (Specify type of place)
While at work? no (e) Means of injury no

23. Signature D. L. Harlan (M. D. or other) MD
Address Claatence? Mo. Date signed Mar 7 1940

751

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 3-40-676
Date Filed MAR-12-1940

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 E E Hoffman

Licensed Embalmer No. 878

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.