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

FILED JUN 15 1940

Registration District No. **678**

Primary Registration District No. **4404**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Phelps

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

(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

3. (a) PRINT FULL NAME Matilda S. Roberts

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex female

5. Color or race white

8. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife J H Roberts

6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased 10 (Month) 14 (Day) 1888 (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>7</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Samuel Simpson

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

14. Maiden name Argeline Powers

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

16. (a) Informant Cora Birmingham

(b) Address St James Mo

17. (a) Burial burial **(b) Date thereof** 5-30-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marion Cem

18. (a) Signature of funeral director W E Rickleder

(b) Address St James Mo

19. (a) Date received local registrar 6/11/40 **(b) Signature of Registrar** Blaise B. Hank
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps

(c) City or town St James Mo
(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 5 day 28
year 1940 hour 1:15 minute 0 M.

21. I hereby certify that I attended the deceased from May 27, 1940, to May 28, 1940
that I last saw him alive on May 28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Angina Pectoris 3/20/40
Myocarditis 1939

Due to _____

Due to _____

Other conditions (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) _____

(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? _____

611 _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Walter H. Forester (M. D. or other) _____

Address St James, Mo **Date signed** 5/30/40

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.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 1240 696

Licensed Embalmer No.....

Date Filed 10/24/0

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.

Registration District No. 678

Primary Registration District No. 4404

Registrar's No.

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

ROWENA MOORE

1. PLACE OF DEATH

(a) County St James
(b) City or town St James
(If outside city or town limits, write "RURAL" and name of township)
(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)

3. (a) PRINT FULL NAME

Matilda S 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 married

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

Months

Days

If less than one day

81

7

14

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)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

Etta B. Howell

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (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

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year hour minute M.

21. I hereby certify that I attended the deceased from
19 to 19

that last saw him alive on
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

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 Wm H. Brewer (M. D. or other)

Address St James Mo Date signed

SUPPLEMENTARY

S-19238