

0. 2  
13-40  
7-39  
X23159

Registration District No. **318**

Primary Registration District No. **2001**

Registrar's No. **837**

1. PLACE OF DEATH:

(a) County **GREENE**

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

(c) Name of hospital or institution:  
**1405 Walnut Ave**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **20**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **DARLENE SUE ROBERTS**

3. (b) If veteran, name war **no.**

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **Wh**

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

6. (b) Name of husband or wife **None**

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

7. Birth date of deceased **Sept 9 1940**  
(Month) (Day) (Year)

8. AGE: Years **9** Months **1** Days **13** If less than one day hr. min.

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

10. Usual occupation **Child**

11. Industry or business

MOTHER FATHER

12. Name **Joshua Roberts**

13. Birthplace **Texas Co. Mo.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Pearl Carter**

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

16. (a) Informant **Joshua Roberts**

(b) Address **1405 Walnut Ave Springfield Mo.**

17. (a) **Burial** (b) Date thereof **Oct 13-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Nickay Ridge Cem**

18. (a) Signature of funeral director **Alvin Stapp**

(b) Address **Springfield Mo**

19. (a) **10-10-40** (b) **W. E. Handley**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Greene**

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

(d) Street No. **1405 Walnut Ave**  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **12** year **1940** hour **2** minute **10 A.M.**

21. I hereby certify that I attended the deceased from **October 6**, 19**40** to **Oct 12**, 19**40**;

that I last saw her alive on **Oct 11**, 19**40** and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial pneumonia.**

Due to **Ankyloemia following ileo colitis.**

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

Other conditions (Include pregnancy within 3 months of death) **III**

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

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

Duration \_\_\_\_\_

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? **Y**

While at work? **Y** (Specify type of place) \_\_\_\_\_

(e) Means of injury \_\_\_\_\_

Signature **W. H. Bunker MD** (M. D. or other) **MD**

Address **410 Warduff Bldg** Date signed **10/12/40**

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

---

---

**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 Wayne Hunkle

Licensed Embalmer No. 3444

P. O. Address Springfield

**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, fact should be so stated above.**