DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
G 14 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25190

Registration District No. 340

Primary Registration District No. 4203

Registrar's No.

1. PLACE OF DEATH:

(a) County HARRISON

(b) City or town NEW HAMPTON. ~~WITE OAK~~ Twp
(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 Fifteen yrs!
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Harrison

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

(d) Street No. City
(If rural, give location)

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

3. (a) PRINT FULL NAME SARRAH REBECA ROBERTS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Edward Roberts

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

7. Birth date of deceased Aug (Month) 5 (Day) 1858 (Year)

8. AGE: Years 82 Months 11 Days 27 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Not Known (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Not Known
15. Birthplace Not Known (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edith Roberts

(b) Address New Hampton Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Kidwell Cemetery

18. (a) Signature of funeral director W G Noble

(b) Address New Hampton Mo

19. (a) Aug 1 '41 (Date received local registrar) (b) G Wilson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8 year 1941 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from April 1, 1941, to July 8, 1941; that I last saw her alive on July 8, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lymph glands around right ear

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 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 R. L. Green D.O. (M.D. or other)

Address New Hampton, Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imp

I X19511

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 me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed W. G. Noble

Licensed Embalmer No. 2904

P. O. Address New Hampton Mo.

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.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25-190

Registration District No. 340 Primary Registration District No. 4203 Registrar's No.

1. PLACE OF DEATH:
(a) County: Harrison
(b) City or town: New Stanton
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Harrison
(c) City or town: New Stanton
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Sarrah R. Roberts
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 82 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation: housekeeper
11. Industry or business
MOTHER FATHER
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) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 8 year 1941 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.

	Duration
Immediate cause of death	
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-25190