

FILLED OCT 25 1941

Registration District No. **537**

Primary Registration District No. **5717**

Registrar's No. **29**

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

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Rural, Lingo Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether
In this community Life
years, months or days)

3. (a) PRINT FULL NAME HENRY C. ROBERTS

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

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

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years (Day) (Year)

7. Birth date of deceased March 11 1865
(Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 0 If less than one day hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business "

MOTHER FATHER

12. Name John B. Roberts
13. Birthplace Wales
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Margaret
15. Birthplace Wales
(City, town, or county) (State or foreign country)

16. (a) Informant E. E. Roberts
(b) Address New Cambria

17. (a) Burial (b) Date thereof Aug 12 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Cambria mo.

18. (a) Signature of funeral director H. J. Hilliland

(b) Address New Cambria mo.

19. (a) Oct 1941 (b) Robert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Macon
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 3 miles south of New Cambria
(If rural, give location)
(e) If foreign born, how long in U. S. A.? — years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 11
year 1941 hour 7 P minute — M.

21. I hereby certify that I attended the deceased from Aug 7, 1941, to Aug 10, 1941, that I last saw her alive on Aug 10, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3 Day

Due to —

Due to —

Other conditions —
(Include pregnancy within 3 months of death)

Major findings: —
Of operations —

Of autopsy 210

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? —

While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Robert (M. D. or other)
Address New Cambria mo. Date signed Aug 11 1941

RECEIVED

District Health Officer No. 10

District File Number 10-41-1907

Date Filed OCT 24 1941

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

H. J. Hilleland

Registered Apprentice No. _____

working under my personal supervision.

Signed

H. J. Hilleland

Licensed Embalmer No. 4019

P. O. Address New Cambria, Md

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.