S. No. 2
A—9-4-41
5-17-39
1 X29484

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. 6518

FILED MAR 8 1943

Registration District No. [illegible] Primary Registration District No. 3025 Registrar's No. 16

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains
(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 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Howell
(c) City or town West Plains
(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 Ella A. Roberton
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 Fernando Roberton
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 2-28-1856 (Month) (Day) (Year)
8. AGE: Years 86 Months 11 Days 11 If less than one day hr. min.
9. Birthplace Winnebago Co. Wisc (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name W. P. Marsure
13. Birthplace (City, town, or county) Mass (State or foreign country)
14. Maiden name Susan Tracy
15. Birthplace (City, town, or county) Mass (State or foreign country)
16. (a) Informant P. D. Roberton
(b) Address West Plains Mo
17. (a) B (Burial, cremation, or removal) (b) Date thereof 2/10/43 (Month) (Day) (Year)
(c) Place: burial or cremation OK Lawn
18. (a) Signature of funeral director Roberts
(b) Address West Plains Mo
19. (a) 2-16-43 (Date received local registrar) (b) Earl Hankins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 6 year 43 hour 3 minute P M.
21. I hereby certify that I attended the deceased from 1929, to 2-6-, 1943; that I last saw h. alive on 2-6-, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchopneumonia	4 days
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Chronic Mitral Insufficiency	

Major findings:
Of operations
Of autopsy 92 F

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 E. C. Fohrer (M. D. or other) MD
Address West Plains Mo Date signed 2-15-43

1125 (Licensed Embalmer's Statement on Reverse Side) B Fhrer

RECEIVED
District Health Officer No. 5
District File Number 343124
Date Filed 8-5-43

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 D D Roberts

Licensed Embalmer No. 3432

P. O. Address West Plains, 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, fact should be so stated above.