

No. 2
1-4-41
17-39
X22390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14470

State File No. _____

FILED MAY 7 1943
Registration District No. 143

Primary Registration District No. 6302

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Haskell Co.

(b) City or town Rural
(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 _____ 42 _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Haskell Co.

(c) City or town Rural
(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 James Washington Roberts

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

4. Sex m 5. Color or race w.

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

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Oct 27 1867
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Roberts

{ 13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

{ 14. Maiden name Larrah Blalock

{ 15. Birthplace n.e. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clara Hamilton

(b) Address Cabool Mo.

17. (a) Burial (b) Date thereof April 4 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Five Feet Cemetery South of Cabool

18. (a) Signature of funeral director Rayford V. Elliott

(b) Address Cabool Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3
year 1943 2 hour 45 minute P.M.

21. I hereby certify that I attended the deceased from March 25 1943 to April 3 1943
that I last saw him alive on April 2 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Lympho sarcoma of breast

Duration 4 months

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 55.2

PHYSICIAN _____

Major findings: Of operations _____

Of autopsy _____

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 A. P. Grass (M. D. or other) 2 190

Address Cabool, Mo. Date signed 4/3/43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 5,

District File Number 549302

Date Filed 5-6-73

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.....

Gaylord V. Elliott

Licensed Embalmer No. 2252

P. O. Address.....

Labooe

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. (143)

Primary Registration District No. (5560)

Registrar's No. 19 20

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Rural Willow Spring 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 42 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Howell
(c) City or town Rural
(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 James W. Rebeck

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

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

6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 27
(Month) (Day) (Year)

8. AGE: Years 25 Months 5 Days 13 min. _____
(If less than one day)

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

10. Usual occupation _____

11. Industry of business _____

12. Name J. Thomas

13. Birthplace Wich Blalock
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Blalock

15. Birthplace M-C
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clara Hamilton
(b) Address Cubert, MO

17. (a) Rural (b) Date thereof April 4, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pin Flat Cemetery
18. (a) Signature of funeral director Raymond V. Elliott
(b) Address Cubert, MO

19. (a) May 15, 1943 (b) Nanette Ferguson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 4 Year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to Lympho Sarcoma of neck
Due to _____

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

Major findings: Of operations _____ Of autopsy _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____ Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-14470