

No. 2-542  
X52873

FILED AUG 7 1943 30

Registration District No. 30

Primary Registration District No. 5102

State File No. \_\_\_\_\_  
Registrar's No. 26

1. PLACE OF DEATH:

(a) County Benton  
(b) City or town Fristoe (Rural Frigate)  
(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 all of life (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Benton  
(c) City or town Fristoe (Rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Elizabeth Roberts

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

4. Sex Female 5. Color or race w 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife W. D. Roberts 6. (c) Age of husband or wife if alive 79 years  
7. Birth date of deceased 27 1865  
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Jonathan Bradley  
13. Birthplace unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Seagr  
15. Birthplace Benton Co, Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant W. D. Roberts  
(b) Address Fristoe, MO

17. (a) burial (b) Date thereof 7-23-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mossy

18. (a) Signature of funeral director W. D. Roberts  
(b) Address W. D. Roberts

19. (a) 7/21/43 (b) Joe A. Logan  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21  
year 1943 hour 16 minute 30 P M.

21. I hereby certify that I attended the deceased from July 8 to July 21  
that I last saw her alive on July 10, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia Duration \_\_\_\_\_

Due to Senility

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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 W. D. Roberts (M. D. or other)  
Address Wassaw mo Date signed 7/26/43

RECEIVED

District Health Officer No. 7,

District File Number 7-43-722

Date Filed 8-4-43

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

*Chas. Albert Kethawa*

Licensed Embalmer No.

4267

P. O. Address

*W. Kethawa, M.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. AUG 27

Registration District No. 30

Primary Registration District No. 5102

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Benton  
(b) City or town Rural, Bristol Sup  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Mary Elizabeth 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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

8. AGE: Years 47 Months 11 Days 2 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1943 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death cremia (Chronic)

Due to senility Duration \_\_\_\_\_

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

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

1318

WRITE PLAINLY—USE NEATNESS  
AVOID BLANK SPACES  
ACK INK—MAKE A PERMANENT RECORD

MOTHER, FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

5-24-277

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