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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 12 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43361

State File No. _____

Registration District No. 275

Primary Registration District No. 3053

Registrar's No. 119

1. PLACE OF DEATH:

(a) County: Phelps

(b) City or town: Rice

(c) Name of hospital or institution: M. Garland Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 6 days
Specify whether _____

In this community: 6 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Shannon

(c) City or town: Emminence Mo.
(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: Martha Eliz Roberts

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec. day: 28
year: 1943 hour: 7:15 minute: 0 M.

21. I hereby certify that I attended the deceased from 12-22, 1943 to 12-28-43
that I last saw her alive on Dec. 28 1943
and that death occurred on the date and hour stated above.

4. Sex: F. 5. Color or race: Wh 6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Earl E. Roberts 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: Dec. 26 1882
(Month) (Day) (Year)

Immediate cause of death: Brain Anoxia

Due to: Various other injuries about the body.

Due to: _____

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

8. AGE: Years: 61 Months: 0 Days: 2 If less than one day: _____ hr. _____ min.

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

10. Usual occupation: Housewife

MOTHER FATHER

11. Industry or business: _____

12. Name: Geo. L. Harris

13. Birthplace: Boone Co Mo (City, town, or county) (State or foreign country)

14. Maiden name: Emma E. Harris

15. Birthplace: Boone Co Mo (City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: _____
Of operations: _____

Of autopsy: _____

Underline the cause to which death should be charged statistically.

16. (a) Informant: Earl E. Roberts

(b) Address: Emminence Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12 28 1943
(Month) (Day) (Year)

(c) Place: burial or cremation: Uniontown Ks

18. (a) Signature of funeral director: Walter Egan

(b) Address: Rice Mo

19. (a) 12/28/43 (Date received local registrar) (b) [Signature] (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): ✓ 081

(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) _____ (Means of injury)

23. Signature: [Signature] (M, D, or other) _____
Date signed: 12/28/43

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

1092

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.....

S. L. V. Jones

Licensed Embalmer No. 3397

P. O. Address.....

Rose me

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH

(a) County Polk
(b) City or town Rolla
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McFarland Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Martha E. Roberts

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

4. Sex 7 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 Dec. 26 - 1903
(Month) (Day) (Year)

8. AGE: Years 61 Months 0 Days _____ If less than one day, _____ min.

9. Birthplace Mo
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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 Dec Day 26 Year 1963 Hour _____ Minute _____ M.

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

Immediate cause of death, _____

Brain Concussion
Due to Various other injuries about body.
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) Accident - (car)
(b) Date of occurrence 12-22-63
(c) Where did injury occur? Hwy 72 - 18 miles from Rolla Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

Highway 72
While at work? _____ (Specify type of work) _____ (c) Means of injury Struck by car

23. Signature William D. [unclear] (M. D. or other) _____
Address Rolla, Mo. Date signed 1/15/64

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-43361