

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2063

State File No. ....

Registration District No. 37

Primary Registration District No. 4049

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Centralia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Boone  
(c) City or town Centralia  
(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 0

3. (a) PRINT FULL NAME Abby 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 Married  
(b) Name of husband or wife Joe Roberts 6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased 1 25 1874  
(Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days 25 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER  
12. Name Charles Andrews  
13. Birthplace Harwood Co Mo  
(City, town or county) (State or foreign country)  
14. Maiden name Mary Andrews  
15. Birthplace Harwood Co Mo  
(City, town or county) (State or foreign country)

16. (a) Informant Deputy Robert  
(b) Address Sturgeon MO

17. (a) Burial (b) Date thereof 12 31 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Church, Centralia

18. (a) Signature of funeral director Wm Damm  
(b) Address Centralia MO

19. (a) 12/30/1943 (b) Chas D Wright  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20  
year 1943 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from Dec 1, 1943  
and that death occurred on the date and hour stated above.  
that I last saw her alive on Dec 19, 1943

Immediate cause of death Cancer of Breast Duration 2 years

Due to.....

Due to Fracture R+ hip ✓

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

Major findings: Cancer of Breast  
Of operations.....

Of autopsy.....

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 Th G White (M. D. or other)

Address Centralia Mo Date signed Dec 20

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

**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 *MD McQuaid*

Licensed Embalmer No. *4313*

P. O. Address *Centerville 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.**

Registration District No. 37 Primary Registration District No. 4049

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

1. PLACE OF DEATH:  
(a) County Boone  
(b) City or town Centralia Columbia  
(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 \_\_\_\_\_ years, months or days  
3. (a) PRINT FULL NAME abby 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: Jan 25 1927  
(Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

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

MOTHER FATHER { 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal) (Specify type of place)

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 Mo (b) County Boone  
(c) City or town Centralia Mo (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 20 Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Dec-1-43 to Dec-20-43 1943  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of breast Duration Several months

Due to Fracture of hip

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death) 50

Major findings: cancer of breast Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_ 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 unknown  
(c) Where did injury occur? Cancer Hospital - Columbia Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Cancer Hospital - Columbia Mo (Specify type of place)  
While at work? no (e) Means of injury \_\_\_\_\_

23. Signature W.S. White (M. D. or other) \_\_\_\_\_  
Address Centralia Mo Date signed \_\_\_\_\_

SUPPLEMENTAL

2063