

FILED JAN 5 1945

Registration District No. 287

Primary Registration District No. 5753

Registrar's No. 140

1. PLACE OF DEATH:

(a) County Maries
(b) City or town Rural Boone
(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 Albert Roberds

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

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

7. Birth date of deceased 11 25 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 0 19 hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Amos Roberds 13. Birthplace Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Barnhart

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Albert Roberds

(b) Address Meta, Missouri

17. (a) Burial (b) Date thereof 12/16/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stokes Cemetery

18. (a) Signature of funeral director Fred H. Gilbert

(b) Address Dixon, Missouri

19. (a) 12/19/44 (b) Erma Bassett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Maries

(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 14
year 1944 hour 2 minute A. M.

21. I hereby certify that I attended the deceased from Nov. 24
1944, to Dec. 14 1944;
that I last saw him alive on Dec 9 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure

Due to Constrictive Heart Failure 1 year.

Due to Aortic Regurgitation years.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations g20
Of autopsy _____

Duration
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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature Wm. A. Gould (M. D. or other) Do.
Address Worcester Mo Date signed 12/15/44

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

RECEIVED

District Health Officer No. _____

District File Number _____

Date Filed 1-4-45

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 _____

1714-44
working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Licensed Embalmer No. 2341

P. O. Address Dixon, Missouri

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.