

FILED JUL 16 1945
Registration District No. 10

Primary Registration District No. 300.2

State File No.

Registrar's No. 82

1. PLACE OF DEATH:

(a) County Audrain
(b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Audrain Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Audrain
(c) City or town Mexico
(If outside city or town limits, write "RURAL")
(d) Street No. Hessy Hotel
(If rural, give location)
(e) Citizen of foreign country? No
If yes, name country

3. (a) PRINT FULL NAME Nettie Braxton Roberts

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

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced W / 2

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

7. Birth date of deceased Oct. 10, 1863
(Month) (Day) (Year)

8. AGE: Years: 81 Months: 8 Days: 26
If less than one day hr. min.

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

10. Usual occupation Widow

11. Industry or business

12. Name Sylvester Roberts

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

14. Maiden name Synthia Roberts

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

16. (a) Informant Fred Roberts

(b) Address Mexico, Mo.

17. (a) Burial (b) Date thereof: 6/10/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Berea (Audrain County)

18. (a) Signature of funeral director Clara Anderson

(b) Address Mexico, Mo.

19. (a) 6/8/45 (b) Margaret H Mackie
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8
year 45 hour 4 minute 20 A.M.

21. I hereby certify that I attended the deceased from June 6 to June 8, 1945
that I last saw her alive on June 7, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Degenerative Hypertension with cardiac failure
Duration 1 week

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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) M

(b) Date of occurrence June

(c) Where did injury occur? Home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

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

23. Signature: Harry F O'Brien (M. D. or other)

Address Mexico, Mo. Date signed 6-8-45

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

RECEIVED

District Health Officer No. 10

District File Number 7-45-1131

Date Filed JUL 13 1945

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. A. Russell

Licensed Embalmer No. 3569

P. O. Address Winnipeg, Man.

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.