

No. 2  
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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37856

FILED NOV 19 1945

State File No. \_\_\_\_\_

Registration District No. 192

Primary Registration District No. 4305

Registrar's No. 19

1. PLACE OF DEATH:

(a) County McDonard

(b) City or town Anderson  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Anderson MO.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 64 Yrs. (Specify whether years, months or days)  
In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonard

(c) City or town Anderson  
(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 JULIA CAROLINE ROARK

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

4. Sex Female / 5. Color or race white 6. (a) Single, widowed, married, divorced divorced

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

7. Birth date of deceased: April, 13, 1881  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>5</u>	<u>27</u>	_____ hr. _____ min.

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

10. Usual occupation Housekeeping

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

12. Name John C. Sellers

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

14. Maiden name Sarrah Tatum

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

16. (a) Informant MRS. L. Tracy  
(b) Address Anderson MO.

17. (a) \_\_\_\_\_ (b) Date thereof 10-12-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anderson MO.

18. (a) Signature of funeral director Chas. Williams

(b) Address Goodman MO.

19. (a) 1-9-45 (b) Virginia Buck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10  
year 1945 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from Oct 9 1945 to Oct 10 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral

Due to Hemorrhage

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

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

Major findings: Of operations \_\_\_\_\_

Of autopsy g20

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? \_\_\_\_\_

23. Signature J. O. Brock (M. D. or other) \_\_\_\_\_  
Address Anderson MO. Date signed 10/11/45

Duration

1 1/2 hours

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1324

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 1143-1110

Date Filed NOV 17 1945

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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 Harren L. Hannah

Licensed Embalmer No. 4400

P. O. Address Neosho, 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.**