

3. No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

682

State File No.

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 236

1. PLACE OF DEATH:
(a) County Quinn
(b) City or town Kennett
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Presnell Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Arkansas (b) County Mississippi
(c) City or town Leachville "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

3. (a) PRINT FULL NAME Jacob Mariou Roach
(b) If veteran, name war no
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan, day 19th
year 1947 hour minute M.
21. I hereby certify that I attended the deceased from

4. Sex male 5. Color or race White
6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife Carrie Lee Roach
(c) Age of husband or wife if alive 23 years
7. Birth date of deceased June 23 1886
(Month) (Day) (Year)

that I last saw him alive on, 19....., and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
60 6 27 hr. min.

Immediate cause of death: cardiac failure
myocardial infarction
chronic nephritis
Due to cardiac failure
myocardial infarction
chronic nephritis

9. Birthplace Bullinger Co. Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation farmer

Due to cardiac failure
myocardial infarction
chronic nephritis
Other conditions (Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business
12. Name William Roach
13. Birthplace Bullinger Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Victoria Turner
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

Major findings: Of operations
Of autopsy
13/13
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Lee Roach
(b) Address Leachville, Ark.
17. (a) Burial (b) Date thereof 1-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lulu Cemetery, Beulah, Mo.
18. (a) Signature of funeral director Howard W. Co.
(b) Address Leachville, Ark.
19. (a) 1-28-1947 (b) Carl Roach
(Date received local registrar) (Registrar's signature)

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?
(e) Means of injury
While at work
23. Signature A. R. Presnell (M. D. or other)
Address Leachville, Mo. Date signed 1-27-47

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

RECEIVED

District Health Office No. 2,

District File Number 247-189

Date Filed 2-7-47

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 W. H. Howard

Licensed Embalmer No. 3959

P. O. Address Leachville, Ark.

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.