

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **16084**

Registration District No. **925**

Primary Registration District No. **4479**

Registrar's No. **84**

1. PLACE OF DEATH:

(a) County **Schuyler**

(b) City or town **Queen city**  
(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 **7.5 yrs.** (Specify whether years, months or days)

In this community **7.5 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Schuyler**

(c) City or town **Queen city**  
(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 **EVERETT FRANKLIN ROBERTS**

3. (b) If veteran, name war **—**

3. (c) Social Security No. **—**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Apr** day **10** year **1947** hour **9** minute **—** P.M.

4. Sex **male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced, **married**

6. (b) Name of husband or wife **Francis Roberts** 6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **March 4 1872**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sep 1 1946** to **Apr 10 1947**, that I last saw him alive on **Apr 10 1947** and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction of Heart**

Duration **10 months**

8. AGE: Years **75** Months **1** Days **4** If less than one day hr. min.

Due to **—**

Due to **—**

9. Birthplace **near Queen city, Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Produce**

11. Industry or business **Produce Business**

12. Name **Dr. Roberts** **9**

13. Birthplace **not known**  
(City, town, or county) (State or foreign country)

14. Maiden name **Julia Starbuck**

15. Birthplace **not known**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. E. F. Roberts**

(b) Address **Queen City, Mo.**

17. (a) **Burial** (b) Date thereof **4-13-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Queen city Wm. H. West**

18. (a) Signature of funeral director **Wm. H. West**

(b) Address **Queen city Mo.**

19. (a) **Apr. 12/47** (b) **Wm. H. West**  
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) **—**

Major findings: Of operations **—** **92 B**

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? **2**

While at work? (Specify type of place) (e) Means of injury **—**

23. Signature **O. P. Green** (M.D. or other) **DO**

Address **Queen City Mo.** Date signed **4-14-47**

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

REGISTRATION  
District No. 10  
District File Number 447-222  
Date Filed APR 15 1947

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 self

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Wm A West

Licensed Embalmer No. 2882

P. O. Address Quincy 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.