

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36635

State File No. _____

No. 300
10-48

BIRTH NO. 124 REG. DIST. NO. 68 PRIMARY REG. DIST. NO. 5267 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY <u>Christian County, Mo.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Christian</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Spokane, Mo. South Balloway Township</u>	c. LENGTH OF STAY (in this place) <u>1 year</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Spokane, Mo. South Balloway Township</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>Residence South Balloway Township</u>		d. STREET ADDRESS (If rural, give location) <u>Rural South Balloway Township</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Cyrus Selly</u>	b. (Middle) _____	c. (Last) <u>Roberts</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 20 - 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH, <u>May 16 - 1874</u>	9. AGE (In years last birthday) <u>73 yr.</u>	UNDER 1 YEAR Months _____	YEAR Days _____	IF UNDER 1 HR. Hours _____	Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Joe Roberts</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Ann</u>	14. NAME OF HUSBAND OR WIFE <u>widowed</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Ben. Roberts, Spokane Mo.</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>120 hrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from June, 1949, to Aug, 1949, that I last saw the deceased alive on 26 Aug, 1949, and that death occurred at 12 m., from the causes and on the date stated above.

23a. SIGNATURE <u>Agnes M. S. O.</u> (Degree or title)	23b. ADDRESS <u>Yadena Mo</u>	23c. DATE SIGNED <u>26 Aug 1949</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	24b. DATE <u>Aug 23 - 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Spokane Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Christian County Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Nov 1 - 1949</u>	REGISTRAR'S SIGNATURE <u>Lutella Leonard</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>T. B. Chaffin Ozark Mo</u>	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED NOV 15 1949
District Health Office No. 6,
District File Number 1149-1152
Date Filed 11-15-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed F. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ogark, 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.