

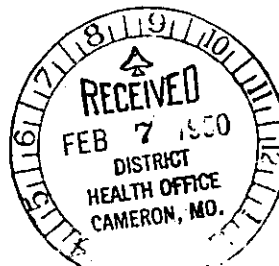
FILED FEB 11 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 3707  
Registrar's No. 56

BIRTH NO. _____		REG. DIST. NO. 374		PRIMARY REG. DIST. NO. 6274		Registrar's No. 56	
1. PLACE OF DEATH a. COUNTY <b>Worth</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Worth</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural-Middlefork Township</b>		c. LENGTH OF STAY (In this place) <b>9 months</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural-Middlefork Township</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Worth, Mo.</b>				d. STREET ADDRESS (If rural, give location) <b>Worth, Mo.</b>			
3. NAME OF DECEASED (Type or Print) <b>Benjamin</b>		a. (First) <b>Franklin</b>		c. (Last) <b>Roach</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>1 17 1950</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed 2</b>		8. DATE OF BIRTH <b>10 26 1864</b>		9. AGE (In years last birthday) <b>85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		11. BIRTHPLACE (State or foreign country) <b>Blakesburg Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Roach</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Tubaugh</b>		14. NAME OF HUSBAND OR WIFE <b>Oliva Bowen Roach</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Merle Richards Worth, Mo.</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Cardiovascular Disease</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last. <b>Chronic nephritis</b>  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.  <b>572x</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1-17-1950</b> to <b>1-17-1950</b> , that I last saw the deceased alive on <b>1-17-1950</b> , and that death occurred at <b>11 A. m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Frank B. Matern</b> (Degree or title) <b>med</b>				23b. ADDRESS <b>Grant City</b>		23c. DATE SIGNED <b>1/19/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>1 19 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Fletcher Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Grant City, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>Feb. 2 - 1950</b>		REGISTRAR'S SIGNATURE <b>Leta E. Dawson</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Arch C. Danfee</b>		ADDRESS <b>Grant City, Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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



---

**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.

Signed \_\_\_\_\_

*Arch C. Dunfee*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

*3252*

P. O. Address \_\_\_\_\_

*Grant City, MD*

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.