

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9806

FILED MAR 31 1950

BIRTH NO. _____		REG. DIST. NO. <u>257</u>		PRIMARY REG. DIST. NO. <u>5881</u>		Registrar's No. <u>11</u>		
1. PLACE OF DEATH a. COUNTY <u>Osage</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>OSAGE</u>				
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <u>Belle</u>		c. LENGTH OF STAY (in this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>R7D BELLE - Mo</u>		d. STREET ADDRESS (If rural, give location) <u>0160</u> <u>0</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION								
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ida</u> b. (Middle) <u>Sophia Jane</u> c. (Last) <u>Robertson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>3-21-1950</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 2</u>		8. DATE OF BIRTH <u>Jan. 6th 1883</u>		
9. AGE (In years last birthday) <u>67</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u>		IF UNDER 4 HRS. Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Summerfield Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George Washington Shanks</u>			13b. MOTHER'S MAIDEN NAME <u>Margarete Johnson</u>		14. NAME OF HUSBAND OR WIFE <u>G.S. Roberts on</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Rainey Robertson Belle Mo</u>				
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) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Angina Pectoris</u> 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. <u>4202</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>6 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		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 <u>June, 1944</u> , to <u>3/21, 1950</u> , that I last saw the deceased alive on <u>3/21, 1950</u> , and that death occurred at <u>4:00am.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>R. N. Schowhals, D.O.</u>				23b. ADDRESS <u>Belle, Mo.</u>		23c. DATE SIGNED <u>3/23/50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-21-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Pilot Knob</u>		24d. LOCATION (City, town, or county) (State) <u>Summerfield Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Mar 22-50</u>		REGISTRAR'S SIGNATURE <u>E. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Clyde Norton ... Mo</u>				

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

RECEIVED
MAR 27 1950
District Health Officer No. 9,
District File Number

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 Vernon Morton

Licensed Embalmer No. 7/125

P. O. Address Linn

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.