

FILED JUN 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16478  
Register No. 496

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Texas</b> b. COUNTY <b>Dallas</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Dallas</b>	
c. LENGTH OF STAY (in this place) <b>3 months</b>		d. STREET ADDRESS (If rural, give location) <b>5522 Columbia Avenue</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St Johns Hospital</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Minnie</b> b. (Middle) <b>Cloud</b> c. (Last) <b>Roberts</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>May 27 1950</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept 4, 1906</b>
9. AGE (in years last birthday) <b>43</b>	IF UNDER 1 YEAR Months <b>43</b>	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours <b>4</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Will Cloud</b>		13b. MOTHER'S MAIDEN NAME <b>Ida Rhea</b>	14. NAME OF HUSBAND OR WIFE <b>Fred Roberts</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs H. C. LeDuc, Springfield, Missouri</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma Breast</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>  ANTECEDENT CAUSES Morbidity 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. <b>170X</b>	
19a. DATE OF OPERATION <b>8-22-47</b>	19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma - Breast Removed</b>		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) (Min.)	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>5-3, 1950, to 5-27, 1950</b> , that I last saw the deceased alive on <b>5-27, 1950</b> , and that death occurred at <b>1:15 P.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Robert W. ...</b>		23b. ADDRESS <b>med. art. bldg. Springfield, Mo.</b>	23c. DATE SIGNED <b>5-27-50</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>May 28, 1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Hazelwood</b>	24d. LOCATION (City, town, or county) (State) <b>Springfield Missouri</b>
DATE REC'D BY LOCAL REG. <b>5-31-50</b>	REGISTRAR'S SIGNATURE <b>W. E. Handley</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>B. F. W. ...</b>	

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

JUL 19 1950

APR 3 1951

APR 5 1951

MAY 16 1959

**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 \_\_\_\_\_

*Lee Mason*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 4568

P. O. Address Springfield, 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.