

FILED JUL 30 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25969

BIRTH NO. _____ REG. DIST. NO. 35-8 PRIMARY REG. DIST. NO. 6215 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY VERNON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY VERNON	
b. CITY (If outside corporate limits, write RURAL and give township) HORTON		c. CITY (If outside corporate limits, write RURAL and give township) HORTON	
c. LENGTH OF STAY (in this place) 46 YRS.		d. STREET ADDRESS (If rural, give location) OSAGE TWP.	
d. FULL NAME OF HOSPITAL OR INSTITUTION: OSAGE TWP.		e. STREET ADDRESS (If rural, give location) OSAGE TWP.	

3. NAME OF DECEASED (Type or Print) KATHERINE-BELLE ROBERTS	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) JULY-12-1951
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH APRIL-22-1865	9. AGE (In years last birthday) 86	10. MONTHS	11. DAYS	12. HOURS	13. MIN.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE.	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME.	11. BIRTHPLACE (State or foreign country) IOWA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME JAMES NORRIS	13b. MOTHER'S MAIDEN NAME KRANRALL	14. NAME OF HUSBAND OR WIFE WESSE ROBERTS (dec)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE.	17. INFORMANT'S SIGNATURE OR NAME Maxilian Cole - Horton, Mo.	18. 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 6 wks Several yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Advanced Age			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331x	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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from **14-7-51**, 19**51**, to **7-5-51**, 19**51**, that I last saw the deceased alive on **6-4**, 19**51**, and that death occurred at **7:30 Am.**, from the causes and on the date stated above.

23a. SIGNATURE M. Cole (Degree or title)	23b. ADDRESS Horton, Mo.	23c. DATE SIGNED 7-17-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY-15-1951	24c. NAME OF CEMETERY OR CREMATORY BALLTOWN CEM.	24d. LOCATION (City, town, or county) (State) VERNON COUNTY - MO
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DATE REC'D BY LOCAL REG. July 19 1951	REGISTRAR'S SIGNATURE Mrs Sarah E Gray 329	25. FUNERAL DIRECTOR'S SIGNATURE Booth Funeral Hse. Rich Hill, Mo.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

1080

DIVISION OF HEALTH OF MD.
District No. 5 - Springfield

RECEIVED JUL 25 1951

Dist. File _____

Date Filed _____

DIVISION OF HEALTH OF MD.
District No. 5 - Springfield

RECEIVED JUL 25 1951

Dist. File 75-1382

Date Filed 7-26-51

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

John H. Hubbard

Licensed Embalmer No. 3585

P. O. Address Butler 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.