

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

10561

State File No.

FILED APR 15 1953

BIRTH NO.

REG. DIST. NO. 198

PRIMARY REG. DIST. NO. 5740

Registrar's No. 175

1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Lingo Twp.</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>Rural-Lingo Twp.</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4 miles S. of New Cambria</u>				d. STREET ADDRESS <u>4 miles S. of New Cambria</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Edward</u>			b. (Middle) <u>Evan</u>		c. (Last) <u>Roberts</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 1, 1953</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>Aug. 29, 1869</u>		9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>New Cambria, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>John J. Roberts</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Meredith</u>		14. NAME OF HUSBAND OR WIFE <u>No.</u>				
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. <u>XXXX</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ruth Seward, Camden, Mo.</u>				ADDRESS	
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) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES <u>none</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>none</u> DUE TO (c) <u>none</u> II. OTHER SIGNIFICANT CONDITIONS <u>none</u> Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>						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 <u>Apr - 1, 1953</u> , to <u>Apr - 1, 1953</u> ; that I last saw the deceased alive on <u>25 May 1953</u> , and that death occurred at <u>9 A - m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>D. W. Roberts M.D.</u>				23b. ADDRESS <u>New Cambria Mo 4-3-53</u>		23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>April 3, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Cambria</u>		24d. LOCATION (City, town, or county) (State) <u>New Cambria, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>4-8-53</u>		REGISTRAR'S SIGNATURE <u>Josephine King</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. H. Hillman</u>		ADDRESS <u>New Cambria Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED 4. 11. 53
MACON COUNTY HEALTH DEPARTMENT
County File No. 4. 53. 78
Date Filed 4. 11. 53

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 H. J. Gilliland

Licensed Embalmer No. 4019

P. O. Address New Cambria 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.