

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13896

State File No. _____

S. No. 300
v. 10-48

FILED MAY 4 1953

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>431</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Springfield</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural 1st Center</u> <u>0390</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Baptist Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Springfield</u> <u>RFD#4 Box 412</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>NETTIE</u>			b. (Middle) _____			c. (Last) <u>ROBERTS</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>April 28 1953</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>16 Nov. 1870</u>		9. AGE (In years - last birthday) <u>82</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 28 HRS. Hours _____ Min. _____	
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 <u>In home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Taylor</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Raymond Hilton Springfield, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Artery Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fracture left hip</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>9 days</u>	
19a. DATE OF OPERATION <u>4-20-53</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fracture hip</u> <u>E9040</u> <u>133</u> <u>21</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Springfield Greene Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>4-19-53</u> m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall</u>			
22. I hereby certify that I attended the deceased from <u>4-19</u> , 19 <u>53</u> , to <u>4-28</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>4-28</u> , 19 <u>53</u> , and that death occurred at <u>2:22 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>James T. Good MD</u>				23b. ADDRESS <u>Springfield, Mo</u>		23c. DATE SIGNED <u>4-29-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/30/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Clear Creek Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Greene County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>4-29-53</u>		REGISTRAR'S SIGNATURE <u>Erith Williamson Reg.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.W. KLINGNER & CO. Springfield, Mo</u>			

(Licensed Emballer's Statement on Reverse Side)

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

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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 Max Rhodes

Licensed Embalmer No. 40711

P. O. Address Springfield

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.