

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH **5233** State File No. **35300**

FILED NOV 9 - 1953

BIRTH NO. _____ REG. DIST. NO. **59** PRIMARY REG. DIST. NO. **4097** Registrar's No. **158**

1. PLACE OF DEATH a. COUNTY Cass		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Cass c. CITY (If outside corporate limits, write RURAL and give township) Rural West Lebanon Township	
b. CITY OR TOWN Rural West Lebanon		c. CITY (If outside corporate limits, write RURAL and give township) Rural West Lebanon Township	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home 2 1/2 mi. N. 1 mi. E. Risle Mo		d. STREET ADDRESS (If rural, give location) 2 1/2 mi. N. 1 mi. E. Risle Mo	

3. NAME OF DECEASED (Type or Print) LUCY		c. (Last) ROOF		4. DATE OF DEATH (Month) (Day) (Year) Oct. 30 - 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Feb. 17 - 1869		
9. AGE (In years last birthday) 84		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Cleveland Mo			12. CITIZEN OF WHAT COUNTRY USA		

13a. FATHER'S NAME John Roof	13b. MOTHER'S MAIDEN NAME Menerva Robinson	14. NAME OF HUSBAND OR WIFE None
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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 Mrs. Albert Long Risle Mo	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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL HEMORRHAGE		2 1/2
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senile ARTERIO SCLEROSIS DUE TO (c) VASCULAR COLLAPSE		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **1/15/1952** to **10/30/1953**, that I last saw the deceased alive on **10/30/1953**, and that death occurred at **11:20 a.m.**, from the causes and on the date stated above.

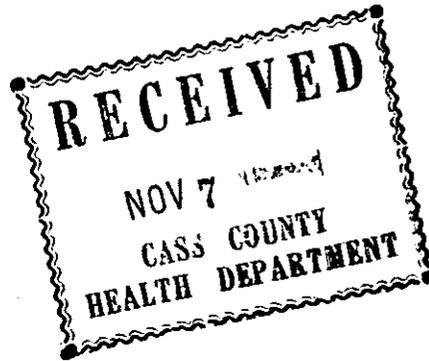
23a. SIGNATURE (Degree or title) C.W. Marsh 2 D.O.	23b. ADDRESS Drexel Mo	23c. DATE SIGNED 10/31/53
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24a. BURIAL, CREMATION, OR OTHER DISPOSITION Burial	24b. DATE 11-2-1953	24c. NAME OF CEMETERY OR CREMATORY Glennville Cem.	24d. LOCATION (City, town, or county) (State) 2 mi North West Risle Mo
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DATE REC'D BY LOCAL REG. Nov 2, 1953	REGISTRAR'S SIGNATURE Norm Barward	25. FUNERAL DIRECTOR'S SIGNATURE Her E. Myers	ADDRESS Cleveland Mo
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(Licensed Embalmer's Statement on Reverse Side)

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



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 Geo. E. Myers

Licensed Embalmer No. 2517

P. O. Address Cleveland mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.