

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **4679**

BIRTH NO. **FILED FEB 23 1954** REG. DIST. NO. **141** PRIMARY REG. DIST. NO. **3025** Registrar's No. **34**

1. PLACE OF DEATH a. COUNTY <b>Howell</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Howell</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>West Plains</b>	c. LENGTH OF STAY (In this place) <b>10 mos.</b>	c. CITY (If outside corporate limits, write RURAL and give township) <b>West Plains</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mask Rest Home</b>		d. STREET ADDRESS (If rural, give location) <b>703 W. Broadway</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>MELISSA</b>	b. (Middle) <b>ANN</b>	c. (Last) <b>ROE</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 7, 1954</b>
-------------------------------------	------------------------------	---------------------------	-------------------------	--

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>April 9, 1869</b>	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) <b>84</b>
-------------------------	----------------------------------	--	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Dallas Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
--	-----------------------------------	--	---

13a. FATHER'S NAME <b>John A. Mustain</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Jane Star</b>	14. NAME OF HUSBAND OR WIFE <b>James Roe, Dec.</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Frankie Beck,</b>	ADDRESS <b>Kaw, Okla.</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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Central Hemorrhage</b>		
	ANTECEDENT CAUSES Morbid 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>331 X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	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 **Dec. 15, 1953**, to **Jan. 7, 1954**, that I last saw the deceased alive on **Jan. 2, 1954**, and that death occurred at **10:40 a.m.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Dr. Richard A. Smith, D.O.</b>	23b. ADDRESS <b>913 W. Main, West Plains, Mo.</b>	23c. DATE SIGNED <b>1-22-54</b>
---	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1/10/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Koshkonong Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Koshkonong, Mo.</b>
--	-----------------------------	--	---

DATE REC'D BY LOCAL REG. <b>1-15-54</b>	REGISTRAR'S SIGNATURE <b>Beatrice Cook</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Leander Shroyer</b>	ADDRESS
--	---	--	---------

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 \_\_\_\_\_

Licensed Embalmer No. 4516

P. O. Address \_\_\_\_\_  
Sharon, N.Y.

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.