No. 300
10-48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9388

BIRTH NO. FILED MAR 29 1954 REG. DIST. NO. 207 PRIMARY REG. DIST. NO. 5756 Registrar's No. 13

1. PLACE OF DEATH
a. COUNTY: MARIES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): JEFFERSON TOWNSHIP
c. LENGTH OF STAY (In this place): 30 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FAMILY HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: MARIES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): JEFFERSON TOWNSHIP 0630 0
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): SARAHA
b. (Middle): ISABELLE
c. (Last): ROBERTS

4. DATE OF DEATH (Month) (Day) (Year): 3 - 20 - 1954

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single 0
8. DATE OF BIRTH: March 1 - 1871
9. AGE (In years last birthday): 83
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house keeper
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (City and State or Foreign Country): MISSOURI 0
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: WILLIAM ROBERTS
13b. MOTHER'S MAIDEN NAME: JANE DREYSSE
14. NAME OF HUSBAND OR WIFE: --------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Bernie Wellar
ADDRESS: Belle, Mo.

MEDICAL CERTIFICATION

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.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

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 331X
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/17/54, *to* 3/20/54, *that I last saw the deceased alive on* 3/19/54, *and that death occurred at* 12:35p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. H. Schoenhals M.D.
23b. ADDRESS: Belle, Mo
23c. DATE SIGNED: 3/22/54

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 3/24/54
24c. NAME OF CEMETERY OR CREMATORY: Pilot Knob
24d. LOCATION (City, town, or county) (State): Osage County, Mo.

DATE REC'D BY LOCAL REG.: 3-26-54
REGISTRAR'S SIGNATURE: Pauline Arnold
25. FUNERAL DIRECTOR'S SIGNATURE: Sarg mann's Funeral Service
ADDRESS:

(Licensed Embalmer's Statement on Reverse Side)

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 Chester Lessman

Licensed Embalmer No. 4178

P. O. Address Bland-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.