. No. 300
. 10.48

FILED JUL 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22849

BIRTH NO. _____ REG. DIST. NO. 139 PRIMARY REG. DIST. NO. 4225 Registrar's No. 45

1. PLACE OF DEATH
a. COUNTY: Holt
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oregon
c. LENGTH OF STAY (In this place): 2 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Holt
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oregon
d. STREET ADDRESS (If rural, give location): 0440 0

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

4. DATE OF DEATH (Month) 7 (Day) 17 (Year) 54

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 10-9-1883
9. AGE (In years last birthday): 70 — 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): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Buchanan Co. Mo
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: John Roberts
13b. MOTHER'S MAIDEN NAME: Emmaline Gibson
14. NAME OF HUSBAND OR WIFE: Olive Roberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): X
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 508-22-9819
17. INFORMANT'S SIGNATURE OR NAME: Mrs Olive Roberts — **ADDRESS**: Oregon, Mo

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): CARCINOMA W METASTISIS (ON BACK) (TO INTESTINES) & LIVER — INTERVAL BETWEEN ONSET AND DEATH: 4 YEARS

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: 1991
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* May, 1954, *to* July 17, 1954, *that I last saw the deceased alive on* July 17, 1954, *and that death occurred at* 11 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: H. E. Coelsin (Degree or title): A.B. D.O.
23b. ADDRESS: Oregon Mo.
23c. DATE SIGNED: 7-20-54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-19-54
24c. NAME OF CEMETERY OR CREMATORY: Stewartsville
24d. LOCATION (City, town, or county) (State): Stewartsville Mo

DATE REC'D BY LOCAL REG.: 7-23-1954
REGISTRAR'S SIGNATURE: James H Crawford
25. FUNERAL DIRECTOR'S SIGNATURE: W. E. Summerfield — **ADDRESS**: Stewartsville Mo

(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 N. E. Summerfield

Licensed Embalmer No. 3007

P. O. Address Stewartsville, N

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.