

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19457

State File No. ....

FILED JUN 18 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 179

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Randolph</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kirksville</b>	c. LENGTH OF STAY (In this place) <b>15 days</b>	c. CITY OR TOWN <b>Cairo</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Laughlin Hospital</b>		STREET ADDRESS (If rural, give location) <b>R. F. D.</b> <span style="float: right;">08801</span>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Thomas</b> b. (Middle) <b>Wesley</b> c. (Last) <b>Roller</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 9, 1956</b>
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Jan. 12, 1893</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Clantonville, Ark.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Jacob W. Roller</b>	13b. MOTHER'S MAIDEN NAME <b>Harriet Barnes</b>	14. NAME OF HUSBAND OR WIFE <b>Imo Bell Hickman Roller</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> <b>X</b>	16. SOCIAL SECURITY NO. <b>498-40-1145</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Imo Bell Roller, Cairo, Mo.</b>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>		
ANTECEDENT CAUSES Morbidity 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 <b>Chr. glomerulonephritis</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4201</b>	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 type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5/25, 1956, to 6/9, 1956 that I last saw the deceased alive on 6/9, 1956 and that death occurred at 9:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE <b>Wm C Plure</b>	(Degree or title) <b>Doc</b>	23b. ADDRESS <b>Kirksville, Mo.</b>	23c. DATE SIGNED <b>6/10/56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>6/10/56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washburn Prairie</b>	24d. LOCATION (City, town, or county) (State) <b>Washburn, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>6 10 56</b>	REGISTRAR'S SIGNATURE <b>Kate Lambert</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Walter Riley, Kirksville, Mo.</b>
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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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 488

P. O. Address Kinshott

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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