

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008485  
STATE FILE NUMBER

FILED MAR 7 - 1958

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Matthews</b>		d. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (IF NOT in hospital, give location) INSTITUTION <b>Mo. Delta Comm. Hosp.</b>			Length of stay in 1b <b>2 Hrs.</b>		d. STREET ADDRESS <b>—</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Newton</b> Last <b>Roberts, Jr.</b>				4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>1958</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-23-1912</b>		9. AGE (In years last birthday) <b>45</b>		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (City and state or country) <b>Matthews, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William N. Roberts</b>				14. MOTHER'S MAIDEN NAME <b>Cerilda Gullett</b>						
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.		17. INFORMANT <b>Fern Roberts, Matthews, Mo.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency, Acute</b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Occlusion, Acute</b>							7 hrs			
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>1. Shock, Intractable.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>—</b> Month, Day, Year a. m. <b>—</b> p. m. <b>—</b>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION <b>Sikeston, Mo.</b>			COUNTY <b>—</b>			STATE <b>—</b>	
21. I attended the deceased <sup>from</sup> <b>2-23-58</b> to <b>—</b> and last saw <sup>him</sup> alive on <b>2-23-58</b> Death occurred at <b>7:45 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE <b>Andro B Sm. MD</b>					22b. ADDRESS <b>Sikeston, Mo.</b>			22c. DATE SIGNED <b>2-25-58</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2-25-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MATTHEWS</b>			23d. LOCATION (City, town, or county) (State) <b>MATTHEWS MO</b>				
24. FUNERAL DIRECTOR <b>Weld Funeral Home - Sikeston Mo</b>				ADDRESS <b>—</b>		25. DATE RECD. BY LOCAL REG. <b>2-26-58</b>		26. REGISTRAR'S SIGNATURE <b>Max Allen Hunter</b>		

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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DATE RECEIVED MAR 3 1958

SCOTT CO. HEALTH DEPT.

CO. FILE No. 358-57

JUN 25 1958

MAR 11 1958

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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..... Raymond Crews.....  
Licensed Embalmer No. 3

P. O. Address Sikeston

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.