

Health,  
Welfare  
Public  
Service

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1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-017165  
STATE FILE NUMBER

FILED MAY 9 1958

Registration District No. 374 Primary Registration District No. 6274 Registrar's No. 22

1. PLACE OF DEATH a. COUNTY <u>Worth County Missouri</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>County</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR <u>Middle Fork</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> TOWN <u>Union Township 6274</u>		c. CITY OR TOWN <u>Worth Missouri</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR INSTITUTION <u>2-miles northwest</u> <u>50-years</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm <u>2-miles northwest</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Celia</u> Middle <u>Alice</u> Last <u>Roberts</u>			4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1958</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March-10-1876</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Month <u>1</u> Day <u>12</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (City and state or country) <u>Worth County 0</u>	
13. FATHER'S NAME <u>Charley F. Long</u>			14. MOTHER'S MAIDEN NAME <u>Emily Smith</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Lowell Roberts</u> Address <u>Worth Missouri</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease with Cardiac Decompensation  
Interval between onset and death 3mos  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_ 4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
Severe Secondary Anemia; Severe Rheumatoid arthritis  
19. WAS AUTOPSY PERFORMED? YES  NO

20a. ACCIDENT  SUICIDE  HOMICIDE   
20b. DESCRIBE HOW INJURY OCCURRED. (Use Part I or Part II of item 18.)  
While working as a janitor  
20c. TIME OF INJURY  
Hour \_\_\_\_\_ Month, Day, Year \_\_\_\_\_  
a. m. \_\_\_\_\_ p. m. \_\_\_\_\_  
20d. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK   
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from April 11, 1958 to Apr 22, 1958 and last saw her alive on April 18  
Death occurred at 10 0 m on the date stated above; and to the best of my knowledge, from the causes stated.  
22a. SIGNATURE (Typed or title)  
Frank B Matteson M D  
22b. ADDRESS  
Grant City, Mo  
22c. DATE SIGNED  
4/24/58

23a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial  
23b. DATE  
April 24-58  
23c. NAME OF CEMETERY OR CREMATORY  
Grant City Cemetery  
23d. LOCATION (City, town, or county) (State)  
Grant City Mo  
24. FUNERAL DIRECTOR  
John Andrews ADDRESS Grant City Mo DATE RECD. BY LEGAL REG. May 1-1958  
26. REGISTRAR'S SIGNATURE  
Lita E. Dawson

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

6581 9 7 1917

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 John Andrews, Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed John Andrews

Licensed Embalmer No. 42

P. O. Address Grant Co

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.