

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033904

STATE FILE NUMBER

FILED OCT 14 1958 Registration District No. 314 Primary Registration District No. 4438 Registrar's No. 37

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Clair</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> <b>St. Clair</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Osceola</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Osceola</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Osceola Med;Center</b>		Length of stay in lb <b>life</b>	d. STREET ADDRESS <b>3 M-S-Osceola</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Elizabeth</b> Last <b>Roberts</b>			4. DATE OF DEATH Month <b>Sept</b> ; Day <b>27</b> , Year <b>1958</b>		
5. SEX <b>Female</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>June 21, 1887</b>		9. AGE (In years at birthday) <b>71</b>
10a. USUAL OCCUPATION (Give kind of work done during part of week immediately preceding death) <b>Housekeeping</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Iconium Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Robert Green</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Collins</b>		14. NAME OF HUSBAND OR WIFE <b>Ebb Roberts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Ebb Roberts, Osceola Missouri</b>		
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>Gastrointestinal Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Peptic Ulcer</b>					<b>48 days</b>
DUE TO (c) <b>5400</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <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		COUNTY STATE
21. I attended the deceased from <b>9-4-58</b> , to <b>9-27-58</b> and last saw her alive on <b>9-27/58</b> Death occurred at <b>3:20 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Hubert M. Mason M.D.</b>			22b. ADDRESS <b>Osceola Missouri</b>		22c. DATE SIGNED <b>9/29/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-1-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Landaker</b>		23d. LOCATION (City, town, or county) (State) <b>Osceola Missouri</b>	
24. FUNERAL DIRECTOR <b>Goodrich Funeral Home, Osceola</b>			25. DATE RECD. BY LOCAL REG. <b>10-9-58</b>	26. REGISTRAR'S SIGNATURE <b>Walter Seewers</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Paul D. Stanton* .....

Licensed Embalmer No. 3990 .....

P. O. Address *Orleans, La.* .....

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.