

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000522

STATE FILE NUMBER

FILED FEB 2 1959

Registration District No. 53

Primary Registration District No. [redacted]

Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <i>Cape Girardeau</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Cape Girardeau</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Whitewater</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <i>2 miles N. Miller</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>2 mi North Miller</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)
3. NAME OF DECEASED (Type or print) First Middle Last <i>WILLIAM CLAY ROBERTS</i>			4. DATE OF DEATH Month Day Year <i>Jan 22, 1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 7, 1897</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (City and state or country) <i>Miller Mo</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. NAME OF HUSBAND OR WIFE <i>Robert</i>	
13a. FATHER'S NAME <i>Byrd G. Roberts</i>		13b. MOTHER'S MAIDEN NAME <i>Rhoda Miller</i>	
14. NAME OF HUSBAND OR WIFE <i>Flossie Clunginger</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no none</i>	
16. SOCIAL SECURITY NO. <i>488-42-7365</i>		17. INFORMANT Address <i>Byrd G. Roberts Jackson Mo</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO (b) <i>Residual ulcer</i> DUE TO (c) <i>5410</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>2 yrs.</i>
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>March 5 to June 27-59</i> and last saw her alive on <i>Sept 15-59</i> Death occurred at <i>Jan 22-59 - 10:00</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>W. J. Schaefer MD</i>		22b. ADDRESS <i>Jackson Mo</i>	
22c. DATE SIGNED <i>1-29-59</i>		23. NAME OF CEMETERY OR CREMATORY <i>Russell Heights</i>	
23a. BURNAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan 25, 1959</i>	
23c. LOCATION (City, town, or county) (State) <i>Jackson Mo</i>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR ADDRESS <i>R Miller Jackson Mo</i>		25. DATE REGD. BY LOCAL REG. <i>Jan 26, 1959</i>	
26. REGISTRAR'S SIGNATURE <i>Mrs. Homer Cooper</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service

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Doctor, coroner, etc. must use only standard nomenclature in Part I. 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 *Gene C. Crawford*

Licensed Embalmer No. *4327*

P. O. Address *Jackson, Miss*

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.