

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018166

STATE FILE NUMBER

FILED JUN 15 1959

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 116

300
-57

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		c. CITY OR TOWN Carthage	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks		d. STREET ADDRESS Rt. 3	
3. NAME OF DECEASED (Type or print) First ELLEN Middle ROBERTS Last		4. DATE OF DEATH June 10, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 3. WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1866
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaking	11. BIRTHPLACE (City and state or country) Falls City, Nebraska
13a. FATHER'S NAME George Mills		13b. MOTHER'S MAIDEN NAME Not available	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Frank Ford, Sr., Rt. 3, Carthage Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation, probable DUE TO (b) Arteriosclerotic heart disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia 3 days			INTERVAL BETWEEN ONSET AND DEATH minutes Years
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.		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 7/16/49, to 6/10/59 and last saw her alive on 6/10/59 Death occurred at 9:45 a. m on the date stated above; and to the best of my knowledge, from the causes stated.		22b. ADDRESS M.D. Carthage, Missouri	
22a. SIGNATURE <i>W. H. Schell, M.D.</i>		22c. DATE SIGNED 6/11/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-13-59	23c. NAME OF CEMETERY OR CREMATORY Park Cemetery	23d. LOCATION (City, town, or county) (State) Carthage, Missouri
24. FUNERAL DIRECTOR ADDRESS KNELL MORTUARY Carthage, Mo.		25. DATE RECD. BY LOCAL REG. 6-11-59	26. REGISTRAR'S SIGNATURE <i>Ely Clifton</i>

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 *O. L. Isbell*

Licensed Embalmer No. *4970*

P. O. Address *Carthage, Mo*

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.