

DI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030090

FILLED VS AUG 24 1959

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 178 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Randolph</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Moberly Mo</u> Length of stay in 1b		c. CITY OR TOWN <u>Moberly</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>537 N. Sturgeon</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>417 N. Fifth St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA ELIZABETH ROPER</u>			4. DATE OF DEATH Month Day Year <u>Aug. 10th 1959</u>			
--	--	--	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <u>never married</u>	8. DATE OF BIRTH <u>Mar. 11-1914</u>	9. AGE (last birthday) <u>45</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
----------------------	-------------------------------	--	--------------------------------------	----------------------------------	-----------------------------	---------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Glasgow</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	---	---	---

13a. FATHER'S NAME <u>John Roper</u>	13b. MOTHER'S MAIDEN NAME <u>Ida Wilson</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
--------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Catherine Butler 106 Horsley</u> Address
--	-------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>May/59</u>
IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <input checked="" type="checkbox"/>	
DUE TO (c) <input type="checkbox"/>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>operation with partial gastric resection 6/10/59</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/> <u>none</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
--	--	--

20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>May/59</u> to <u>Aug. 10/59</u> and last saw her alive on <u>Aug 1/59</u>	
Death occurred at <u>8:10 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>A. R. E. Moberly Mo</u> (Degree or title)	22b. ADDRESS <u>Moberly Mo</u>	22c. DATE SIGNED <u>8/12/59</u> (State)
---	--------------------------------	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 14-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fayette Mo</u>	23d. LOCATION (City, town, or county)
---	-----------------------------	--	---------------------------------------

24. FUNERAL DIRECTOR <u>Robert L. Barr 417 N. Fifth</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-14-59</u>	26. REGISTRAR'S SIGNATURE <u>Trabelshaw</u>
---	---	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Robert L. Carr

Licensed Embalmer No. 3190

P. O. Address Woburn, Mass.

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.