

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1960

-60-001138

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 19

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|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Greene | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Missouri b. COUNTY Shannon | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield | | Length of stay in 1b 3 Day | c. CITY OR TOWN EMINENCE | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) No Street Address | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MARION Middle Roberts Last Roberts | | | 4. DATE OF DEATH Month JANUARY Day 5 Year 1960 | | | |
| 5. SEX MALE | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1-25-1878 | 9. AGE (last birthday) 71 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (City and state or country) Missouri | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Alexander Roberts | | 13b. MOTHER'S MAIDEN NAME MARY TAYLOR | | 14. NAME OF husband WIFE CORA Roberts | | |
| 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. yes | 17. INFORMANT Address Burge Hospital Record Spfd. Mo. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage left middle Cerebral artery | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <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 <u>1-2-60</u> to <u>1-5-60</u> and last saw him alive on <u>1-5-60</u> Death occurred at <u>4:30 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE (Degree or title) Dashley M.D. | | | 22b. ADDRESS Springfield Mo | | 22c. DATE SIGNED 1-7-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE 1-5-1960 | 23c. NAME OF CEMETERY OR CREMATORY New Eminence Mt. View, Missouri | 23d. LOCATION (City, town, or county) (State) | | | |
| 24. FUNERAL DIRECTOR ADDRESS DUNCAN Fall Home Mt. View, Mo. | | 25. DATE RECD. BY LOCAL REG. JAN 8, 1960 | 26. REGISTRAR'S SIGNATURE Effie S. Melton | | | |

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 Gene E. Hunter

Licensed Embalmer No. 473

P. O. Address Spfld, Ill

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.