

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 2 1960

=60-001296

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 10

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Howard</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Howard</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fayette, Missouri</b>		Length of stay in 1b <b>19 days</b>		c. CITY OR TOWN <b>Fayette</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lee Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>309 Corprew</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELEANOR</b> Middle <b>JANE</b> Last <b>ROBERTS</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>21.</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/5/1872</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Appanoose Co. Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Amaziah Joseph Bacus</b>			13b. MOTHER'S MAIDEN NAME <b>Matilda Jane Swaengen</b>		14. NAME OF HUSBAND OR WIFE <b>John H. 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. <b>None</b>		17. INFORMANT Address <b>Louise Turner, Fayette, Mo.</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>Coronary Thrombosis 2 hrs</b> DUE TO (b) <b>Chronic Coronary Disease 5 yrs</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		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 <b>1-8-60</b> to <b>1-21-60</b> and last saw her alive on <b>1-21-60</b> Death occurred at <b>Fayette Mo 1:00 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Walter Bloom M.D.</b> (Degree or title)			22b. ADDRESS <b>Fayette Mo</b>		22c. DATE SIGNED <b>1-29-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/24/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Ridge Cemetery</b>		23d. LOCATION (City, town, or county) <b>Fayette, Missouri</b>			
24. FUNERAL DIRECTOR <b>Kelpha A. Carr</b> ADDRESS <b>Fayette, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>1-29-60</b>		26. REGISTRAR'S SIGNATURE <b>Katherine Welch</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

