

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-010202

STATE FILE NUMBER

AMENDED

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 45

FILED VS MAR 15 1961

| | | | | | | | |
|---|---------------------------|--|---|--|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY <u>RANDOLPH</u> | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOBERLY</u> | | a. STATE <u>MO</u> | | b. COUNTY <u>MONROE</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WOODLAND HOSP.</u> | | Length of stay in 1b <u>10 HRS.</u> | | c. CITY OR TOWN <u>WOODLAWN TWP</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS <u>7 1/2 MI. N. of HOLLIDAY</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLA MAE ROBERTS</u> | | | | 4. DATE OF DEATH Month Day Year <u>MARCH 6 1961</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-16-87</u> | 9. AGE (last birthday) <u>74</u> | IF UNDER 1 YEAR | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (City and state or country) <u>MONROE CO. MO.</u> | | Months <u>1</u> Days <u>20</u> | Hours <u>-</u> Min. <u>-</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>USA.</u> | | | 13a. FATHER'S NAME <u>ROBERT A. ALEXANDER</u> | | 13b. MOTHER'S MAIDEN NAME <u>AMANDA JANE PIERCE</u> | | 14. NAME OF HUSBAND OR WIFE <u>CALVIN D. ROBERTS</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>DEPENDANT</u> | | 17. INFORMANT <u>C.D. ROBERTS</u> Address <u>R.F.D. #1</u> | | |
| 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>Unknown</u> |
| IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular Disease</u> | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ | | | | | | | |
| DUE TO (c) _____ | | | | | | | |
| 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 a.m. 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 <u>March 6th</u> to <u>March 6th</u> and last saw <u>her</u> alive on <u>March 6th</u> | | | | | | | |
| Death occurred at <u>10:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>Thos S Fleming</u> (Degree or title) | | | | 22b. ADDRESS <u>Moberly Missouri</u> | | 22c. DATE SIGNED <u>3-6-61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>3/9/1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE</u> | | 23d. LOCATION (City, town, or county) (State) <u>PARIS, MO.</u> | |
| 24. FUNERAL DIRECTOR <u>E.H. AGNEW</u> ADDRESS <u>PARIS, MO.</u> | | | 25. DATE RECD. BY LOCAL REG. <u>3-6-61</u> | | 26. REGISTRAR'S SIGNATURE <u>J. Caldwell</u> | | |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MINN 10 1961

OCT 5 1961

JUN 25 1962

MAR 8 1962

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 E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, 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.