

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024261

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 43

Primary Registration District No. 307

Registrar's No. 236

AMENDED

FILED AUG 9 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH p. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		c. CITY OR TOWN MARMADUKE	
Length of stay in lb 9 DAYS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL		d. STREET ADDRESS (If outside, give location) NONE	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ALBERT PRENTIS ROBERTS			4. DATE OF DEATH Month Day Year AUGUST 3, 1961
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-29-97
9. AGE (last birthday) 64		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	11. BIRTHPLACE (City and state or country) HUNTINGTON, TENNESSEE
12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME MARCUS F. ROBERTS		13b. MOTHER'S MAIDEN NAME MARY L. DICKERSON	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) YES WWI		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, 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) BILATERAL PNEUMONITIS.			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) COMA			
DUE TO (c) CEREBRAL ENCEPHALOMALACIA			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CEREBRAL ARTERIOSCLEROSIS.			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 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 VA JULY 25, 1961 to AUGUST 3, 1961 and last seen her at home . Death occurred at 2:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) DAVID W. MILLER, M.D., Actg. Pathologist		22b. ADDRESS VA Hospital, Poplar Bluff, Mo.	22c. DATE SIGNED 8/3/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-5-61	23c. NAME OF CEMETERY OR CREMATORY Harvey's Chapel	23d. LOCATION (City, town, or county) (State) Marmaduke, Ark., P. 2
24. FUNERAL DIRECTOR Irby Funeral Home, Rector, Ark.		25. DATE RECD. BY LOCAL REG. 8/2/1961	26. REGISTRAR'S SIGNATURE Dulma Graham

AUG 17 1961

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.