

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024850

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 657

AMENDED

FILED JUL 17 1961

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| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> | | Length of stay in 1b <u>40 yrs.</u> | c. CITY OR TOWN <u>Springfield</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>1314 State</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>411 S. New</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|----------------------------------|--|---|--|---|
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wiley</u> Last <u>Roberts</u> | | | 4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1961</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</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>1-28-1874</u> | 9. AGE (last birthday) <u>87</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | | 11. BIRTHPLACE (City and state or country) <u>Taney County, Mo.</u> | |
| 10c. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>James Roberts</u> | | 13b. MOTHER'S MAIDEN NAME <u>Missouri Alley</u> | |
| 13c. NAME OF HUSBAND OR WIFE <u>Sarah 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>none</u> | |
| 17. INFORMANT <u>Mrs. Sarah Roberts, Springfield, Mo.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs.</u> | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a). <u>Rheumatic Heart Disease.</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 <u> </u> Month, Day, Year <u> </u> | 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 |

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|---|---------------------------------------|---------------------------------------|
| 21. I attended the deceased from <u>July 1959</u> to <u>July 8, 61</u> and last saw him alive on <u>11 June 1961</u> Death occurred at <u>1:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | |
| 22a. SIGNATURE <u>H.C. Callaway, Jr MD</u> (Degree or title) | 22b. ADDRESS <u>Springfield Mo</u> | 22c. DATE SIGNED <u>11 July 61</u> |

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burned</u> | 23b. DATE <u>7-11-1961</u> | 23c. NAME OF CEMETERY OR CREMATOR <u>Hopedale Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Christian Co. Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Rea Ramey, Springfield, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-14-61</u> | 26. REGISTRAR'S SIGNATURE <u>Effie S. Mellon</u> |

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 *Lee Mason*

Licensed Embalmer No. 4568

P. O. Address Springfield, 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.