

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044180

STATE FILE NUMBER

Registration District No. 119 Primary Registration District No. 5443 Registrar's No. 65

AMENDED

FILED DEC 27 1961

1. PLACE OF DEATH a. COUNTY <u>gasconade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Roark</u>		Length of stay in 1b <u>8Mo24 days</u>		c. CITY OR TOWN <u>Owensville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home Frene Valley Nursing</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rural Route</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mag Nora MAGNOLIA Jane ROBERTS</u>				4. DATE OF DEATH Month Day Year <u>December 13 1961</u>					
5. SEX <u>female</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>6-14-1881</u>		9. AGE (last birthday) <u>80</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>Red Bird, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Jim Cahill</u>			13b. MOTHER'S MAIDEN NAME <u>Lucy Adkins</u>			14. NAME OF HUSBAND OR WIFE <u>Joseph M. 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 Address <u>Joseph M. Roberts Owensville, 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>Bronchopneumonia</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</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) <u>Arteriosclerotic heart disease</u>						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 checked="" 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>3-1-61</u> to <u>12-13-61</u> and last saw her ^{her} <u>12-13-61</u> Death occurred at <u>4:16 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Carroll T. Shaw, M.D.</u>				22b. ADDRESS <u>Hermann, Mo.</u>			22c. DATE SIGNED <u>12-14-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>12-16-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Owensville, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Gottenstroeter Funeral Home</u> <u>Owensville, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>12-15-1961</u>		26. REGISTRAR'S SIGNATURE <u>Delma Uffelmann</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Melford H. N. Winter

(Licensed Embalmer's Statement on Reverse Side)

JAN 25 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 MR, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Michael H H [Signature]

Licensed Embalmer No. 3838

P. O. Address OWENSUM

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.

416 P.M. 9/17