

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034590

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 169

STATE FILE NUMBER

FILED OCT 8 1962	
<p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <u>Howell</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains.</u> Length of stay in lb <u>32 days</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>West Plains Memorial Hosp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u></p> <p>c. CITY OR TOWN <u>Pomona</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>Route #1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>
<p><b>3. NAME OF DECEASED</b> First Middle Last <u>Shellina Arthimishia Roberds</u></p>	
<p><b>4. DATE OF DEATH</b> Month Day Year <u>October 1, 1962</u></p>	
<p><b>5. SEX</b> <u>Female</u></p>	<p><b>6. COLOR OR RACE</b> <u>White</u></p>
<p><b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>1/23/1896</u></p>
<p><b>9. AGE</b> (last birthday) <u>66 yrs.</u></p>	<p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>
<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b></p>	<p><b>11. BIRTHPLACE</b> (City and state or country) <u>Howell County, Mo.</u></p>
<p><b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u></p>	<p><b>13a. FATHER'S NAME</b> <u>C.L. Swan</u></p>
<p><b>13b. MOTHER'S MAIDEN NAME</b> <u>Almeda Pearson</u></p>	<p><b>14. NAME OF HUSBAND OR WIFE</b> <u>J.I. Roberds</u></p>
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p>	<p><b>16. SOCIAL SECURITY NO.</b></p>
<p><b>17. INFORMANT</b> <u>J. I. Roberds, Rt 1, Pomona, Mo.</u></p>	<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Kulmangy Edema, acute</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary heart failure</u></p> <p>DUE TO (c) <u>Arteriosclerosis heart Dis.</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis, gen. Diabetes</u></p> <p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	<p><b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/></p>
<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)</p>	<p><b>20c. TIME OF INJURY</b> Hour Month, Day, Year</p>
<p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/></p>	<p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p><b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE</p>	<p><b>21. I attended the deceased from</b> <u>1956</u> to <u>10-1-62</u> and last saw her alive on <u>10-1-62</u></p> <p>Death occurred at <u>11:10AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>
<p><b>22a. SIGNATURE</b> (Print name and title) <u>Jack N. Wiles MD West Plains, Mo</u></p>	<p><b>22b. ADDRESS</b> <u>10-2-62</u></p>
<p><b>22c. DATE SIGNED</b></p>	<p><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u></p>
<p><b>23b. DATE</b> <u>10/4/1962</u></p>	<p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Dripping Springs Cemetery near West Plains, Missouri</u></p>
<p><b>23d. LOCATION</b> (City, town, or county) (State)</p>	<p><b>24. FUNERAL DIRECTOR</b> <u>Carter Funeral Home, West Plains, Mo.</u></p>
<p><b>25. DATE RECD. BY LOCAL REG.</b> <u>10-6-62</u></p>	<p><b>26. REGISTRAR'S SIGNATURE</b> <u>Beatrice Cook</u></p>

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

OCT 9 1962

OCT 10 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 Richard Carter

Licensed Embalmer No. 4516

P. O. Address West Plains, 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.