

SEP 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

28850
Do not use this space.

1. PLACE OF DEATH

(a) County... cedar / Registration District No. 165
(b) Township... W. Washington / Primary Registration District No. 5234
(c) City... ~~Captlinger Mills, Mo.~~ Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ¹⁶³ Grave Roberts

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF S. C. Roberts
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 12 1879
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
60 8 11

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill. 9

13. NAME Joseph Stamp 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 1

15. MAIDEN NAME Hattie Keith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

17. INFORMANT S. C. Roberts (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE Brush Cem. e. DATE August 24 1939

19. FUNERAL DIRECTOR (NAME) W. C. Davis & Co. (ADDRESS) Stockton, Mo.

20. FILED Sep. 4 1939 Mrs Winnie Carleton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 23 1939

22. I HEREBY CERTIFY, That I attended deceased from August 22, 1939 to August 23, 1939

I last saw her alive on August 22, 1939. Death is said to have occurred on the date stated above, at 11:30 P.M.
The principal cause of death and related causes of importance were as follows:

Angina Pectoris

Date of onset

?
About Aug. 1

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signed) Robert Wray (Address) Osceola, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X18603

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.....
....., Registered Apprentice No.....
working under my personal supervision.

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 this body is not embalmed, above space should be left blank.

Embalsmed
7/21