

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38859**

Registration District No. _____

Primary Registration District No. **4005**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Andrew**
 (b) City or town **Amoyonia**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **2 yrs.**
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Andrew**
 (c) City or town **Amoyonia**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **30**
 year **1939** hour **6** minute **40 A.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**
 Due to **atherosclerosis**
 Due to **Dr. Myer Co. Int.**
 Other conditions (Include pregnancy within 3 months of death) _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME **Mary Elizabeth Roat**
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **William Roat** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Oct 15 - 1851**
 (Month) (Day) (Year)

8. AGE: Years **88** Months **1** Days **15** If less than one day _____ hr. _____ min.

9. Birthplace **Gilmore Ohio**
 (City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER
 12. Name **Stillion**
 13. Birthplace **un known un known**
 (City, town, or county) (State or foreign country)
 14. Maiden name **un known un known**
 15. Birthplace **un known un known**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Thomas Bert Ross**
 (b) Address **Amoyonia mo**
 17. (a) **Burial** (b) Date thereof **12-2-1939**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **amoyonia**

18. (a) Signature of funeral director **E. H. Breit**
 (b) Address **Savannah mo**
 19. (a) **12-2-39** (b) **J. W. Holcomb**
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
 While at work? _____ (Specify type of place) (Manner of injury)
 23. Signature **Walter Coyle** (M. D. or other) _____
 Address **Savannah mo** Date signed _____

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.

1239-1687

~~DEC 11 1939~~

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah

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.