

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2706

FILED FEB 19 1940

Registration District No. 477 Primary Registration District No. 2002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: 3  
 (a) County Jasper  
 (b) City or town Joplin  
 (c) Name of hospital or institution: 2119 Wall Street  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 Weeks  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME William B. Roberts  
 3. (b) If veteran, NAME WAR \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widower  
 6. (b) Name of husband or wife Katherine Roberts  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased January 14, 1862  
 (Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days 26  
 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace Bolivar Missouri  
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Harness Maker  
 11. Industry or business Harness Shop

MOTHER FATHER  
 12. Name William Roberts  
 13. Birthplace Unknown  
 14. Maiden name Mary Hopper  
 15. Birthplace Tennessee  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature C. J. Wirtz  
 (b) Address 2119 Wall St., Joplin, Mo.

17. (a) Burial (b) Date thereof 1-11-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Sheldon Mo. Cemetery

18. (a) Signature of funeral director Hurlbut Und. Co.  
 (b) Address 212 Joplin St., Joplin, Mo.

19. (a) 1-10-40 (b) Ed James  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 9  
 (a) State Missouri (b) County Barton  
 (c) City or town Lamar  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. E. Pacific Street  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 9  
 year 1940 hour 9 minute 50 P. M.

21. I hereby certify that I attended the deceased from Dec 24, 1939 to Jan 9, 1940  
 that I last saw him alive on Jan 8, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion - 9410  
 Due to Thrombus forming in Blood Stream  
 Due to \_\_\_\_\_

Other conditions Hypertension  
 (Include pregnancy within 6 months of death)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically

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)  
 (a) Means of injury \_\_\_\_\_  
 23. Signature Ed James or other \_\_\_\_\_  
 Address 2114 Joplin Date signed Jan 10 1940

WHILE I LABORED UNFADING BLACK INK—MAKE A PERMANENT RECORD 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.

RECEIVED

District Health Officer No. 6,

District File Number 240-549

Date Filed FEB 15 1940

---

---

**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 Steve D. Parks

Licensed Embalmer No. 2548

P. O. Address Joplin 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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

2706  
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 411  
(b) Township \_\_\_\_\_ Primary Registration District No. 2002 Registered No. \_\_\_\_\_  
(c) City Joplin (d) 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

William B. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-14-1962

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
77 11 26

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 1-10 1940 Ed H. James Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-9, 1940

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

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) A. W. Desfelt, M. D.

(Address) Joplin

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
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.

SUPPLEMENTARY

