

FILED APR 8 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10173

Registration District No. 74

Primary Registration District No. 5113

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Boone INDO
(b) City or town Rocky Fork T.B. # Royal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: no
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no (Specify whether
In this community 16 1/2 years, months or days)

3. (a) PRINT FULL NAME Willis S. Roberts

3. (b) If veteran, name war No 3. (c) Social Security No. NO

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Laura Roberts 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased Feb 16 1862
(Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days 11 If less than one day, hr. min.

9. Birthplace Boone Co. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farmer

MOTHER FATHER { 12. Name S. S. Roberts
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Martha B K
15. Birthplace Dont KALOW O
(City, town, or county) (State or foreign country)

16. (a) Informant Selas Roberts
(b) Address Columbia Mo

17. (a) Burial (b) Date thereof March 28 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Red Top Cem

18. (a) Signature of funeral director RORRIGATE
(b) Address Columbia, Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
(c) City or town Hallsville Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Route 5 Centralia
(If rural, give location)
(e) If foreign born, how long in U. S. A.? life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27th
year 1940 hour 12:45 minute PM
21. I hereby certify that I attended the deceased from Nov 6th
1940 to Nov 29th 1940
that I last saw h alive on Nov 26th 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Atherosclerosis
Hypertension
Due to Chr. Myo carditis
Due to Apex
Other conditions (Include pregnancy within 3 months of death)

Duration 3/26
?
?
PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings: Of operations
Of autopsy

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?

23. Signature W. Turner M.D. (Specify type of place) (e) Means of injury
Address Centralia Mo Date signed 3/27/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

Lyman H. Sprinkle

Licensed Embalmer No. 14013

P. O. Address Columbia, 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.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 74

Primary Registration District No. 3113

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Rockyfork
(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..... (Specify whether)

years, months or days)

3. (a) PRINT FULL NAME Willie S. Roberts

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>1</u>	<u>11</u>	hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER, FATHER {

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 4-2-40 (Date received local registrar) (b) Mrs. F. L. Luvette (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 27 year 1940 hour..... minute..... M.

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

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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) (e) Means of injury.....

23. Signature G. W. Turner (M. D. or other) Address Centralia Mo. Boone

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-10173 1940