

14151

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. 7Registration District No. 13Primary Registration District No. 5017Registrar's No. 14

## 1. PLACE OF DEATH:

(a) County ANDREW  
 (b) City or town ST. JOSEPH #3  
 (If outside city or town limits, write "RURAL" and name of township)  
Jefferson - Rural 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community ENTIRE LIFE (Specify whether  
 years, months or days) 163

8. (a) PRINT FULL NAME THOMAS ARTHUR ROBERTS

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if

7. Birth date of deceased JAN 15 1868  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
74 2 23 hr. min.9. Birthplace ANDREW CO MO  
(City, town, or county) (State or foreign country)10. Usual occupation FARMER11. Industry or business 112. Name ARTHUR ROBERTS13. Birthplace UNKNOWN TENN  
(City, town, or county) (State or foreign country)14. Maiden name PRISCILLA McDONALD15. Birthplace UNKNOWN IND  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature E. F. Breat(b) Address Savannah Mo17. (a) Burial (b) Date thereof 4-10-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation CUMBERLAND RIDGE18. (a) Signature of funeral director J. Fred Johnson(b) Address Savannah Mo19. (a) Apr. 10-40 (b) Mrs. Jennie Rash  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew  
 (c) City or town St. Joseph Rural 3  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Rural RR 3 # St Joseph mo  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8  
year 1940 hour 7 minute 2 A. M.21. I hereby certify that I attended the deceased from March 25  
1940, to April 8, 1940  
that I last saw him alive on April 2nd, 1940  
and that death occurred on the date and hour stated above.Immediate cause of death Terminal Hypertensive Pneumonia DurationDue to Cerebral Hemorrhage 15 yrs  
2 complete paralytic 18 yrsDue to Hypertension 15 yrs

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: J22Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? 215

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature W. B. Kelley (M. D. or other) MD  
Address Savannah Mo Date signed 4/10/40

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. 11;  
District File Number 540-752  
Date Filed MAY 16 1940

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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.....

J. Fred Turkum, Registered Apprentice No. 1279  
working under my personal supervision.

Signed J. Fred Turkum  
Licensed Embalmer No. 1279  
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.