

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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

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

Do not use this space.

25052

1. PLACE OF DEATH  
 County DeKalb Registration District No. 260  
 Township Calfax Primary Registration District No. 5362  
 City 163 (No. Alice A Roberts) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Alice A Roberts

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

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 Ernest Roberts

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April - 1 - 1879 -

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>60</u>	<u>10</u>	<u>3</u>	

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 3, 1940

22. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1927, to July 3, 1940  
 I last saw him alive on July 2, 1940. Death is said to have occurred on the date stated above, at 4. P. m.  
 The principal cause of death and related causes of importance were as follows:  
Pulmonary Tuberculosis Date of onset \_\_\_\_\_

Other contributory causes of importance: 22

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? no  
 If so, specify \_\_\_\_\_ (Signed) Mr. S. Hale, M. D.  
 (Address) Ostborn Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DeKalb Co Mo.

FATHER  
 13. NAME George Kratzer  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER  
 15. MAIDEN NAME Ellen J. Olive  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. Va.

17. INFORMANT (ADDRESS) George Kratzer, Ostborn Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Ostborn Mo. DATE July 5, 1940

19. UNDERTAKER (ADDRESS) J. S. Stewart, Stewartville Mo.

20. FILED July 5, 1940 Mildred Mc Mahill Registrar.

235

RECEIVED

District Health Officer No. 11,

District File Number

840-1294

Date Filed

AUG 14 1940

Statement by Licensed Embalmer.

I hereby certify that the body whose name is recorded  
on reverse side of this Certificate was embalmed by me.

F. J. Dixon

Licensed Embalmer # 952

Stewartville mo

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **25052**  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **260**

Primary Registration District No. **5362**

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

1. PLACE OF DEATH:

(a) County **De Kalb**  
(b) City or town **Osage T.P.**  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **De Kalb**  
(c) City or town **Rural**  
(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.

3. (a) PRINT FULL NAME

**Alice A. Roberts**

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

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

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **m**

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

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_

(Month) (Day) (Year)

8. AGE:

Years **60** Months **10** Days **3**

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_

(Date received local registrar)

(b) **Mildred M. Mahily**  
(Registrar's signature)

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **3**  
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 \_\_\_\_\_

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

23. Signature **J. S. Gale** (M. D. or other) \_\_\_\_\_  
Address **Osage** \_\_\_\_\_

SUPPLEMENTARY

