

Registration District No. **19**

Primary Registration District No. **5025**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **ATCHISON**
 (b) City or town **ROCK PORT, MO**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
County Home 1st
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **5 mo.**
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **ATCHISON**
 (c) City or town **ROCK PORT, MO**
 (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 **JOHN HENRY 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, **Divorced**

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 Months Days If less than one day
70 0 17 hr. min.

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

10. Usual occupation **MECHANIC**

11. Industry or business _____

MOTHER FATHER { 12. Name **CHAS. Roberts**
 13. Birthplace **UNKNOWN** (City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name **SHARON TYSON**
 15. Birthplace **UNKNOWN** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Linden Perry, Supt.**
 (b) Address **Rock Port, MO**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **1-21-1941** (Month) (Day) (Year)

(c) Place: burial or cremation **LINDEN**

18. (a) Signature of funeral director **Frank Bechtelmann**
 (b) Address **Rock Port, MO**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **19** year **1941** hour **7** minute **30** M.

21. I hereby certify that I attended the deceased from **Jan-1** to **Jan-19**, 1941; that I last saw him alive on **Jan-19**, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death **Influenza** Duration **19 days**

Due to **Pneumonia (lobar)** 9 days

Due to **Emphysema of lung** 5 days

Other conditions (Include pregnancy within 3 months of death) **32W**

Major findings: Of operations _____

Of autopsy **no 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? _____

(Specify type of place) _____
 While at work? (a) Means of injury _____

23. Signature **J. M. Davis** (M. D. or other) **O**
 Address **Rock Port, MO** Date signed **1-21-41**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 *Grady Bartholomew*

Licensed Embalmer No. *3173*

P. O. Address *Rock Port, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1595-

Registration District No. 19

Primary Registration District No. 5025

Registrar's No.

1. PLACE OF DEATH:

(a) County Atchison
(b) City or town Clay Sup.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
County Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 months
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Atchison
(c) City or town Rockport
(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

John Henry 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 wid
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 Months Days If less than one day
70 - 17 hr. min.

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

10. Usual occupation merchant

11. Industry or business _____

12. Name Chas Roberts

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

14. Maiden name Sarah Tyson

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

16. (a) Informant Ernest Berry sup
(b) Address Rockport mo

17. (a) Burial (b) Date thereof 1-21-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation London

18. (a) Signature of funeral director Wm Partholomen
(b) Address Rockport mo

19. (a) 1-21-1941 (b) Maury H. Chamberlain
(Date received local registrar) (Registrar's signature)

MEANS OF CERTIFICATION

20. DATE OF DEATH: month Jan day 19
year 1941 hour _____ minute _____ 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 Influenza
Pneumonia Local
Due to _____
Gangrene of lung
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____
Of autopsy no

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) (e) Means of injury _____

23. Signature Wm Davis (M. D. or other) _____
Address Rockport mo Date signed _____

SUPERSEDED BY MISSOURI STATE BOARD OF HEALTH

WHILE I LAYED OUT THIS CERTIFICATE, I MADE A PERMANENT RECORD

S-1595