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23159

LED MAR 21 1941

State File No. \_\_\_\_\_

Registration District No. 184

Primary Registration District No. 6270

Registrar's No. 30

1. PLACE OF DEATH: Christian  
 (a) County Christian  
 (b) City or town Rural S. Galloway  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
years, months or days

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

3. (a) PRINT FULL NAME Donald Wayne Roberts  
 (b) If veteran, name war ✓  
 (c) Social Security No. ✓

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec. day 10<sup>th</sup> 1940  
 year 1940 hour 3 minute 9 P. M.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widow  
 (b) Name of husband or wife L (c) Age of husband or wife if alive \_\_\_\_\_ years  
 (d) Birth date of deceased Mich 31 1940  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 5 1940 to Dec 10 1940  
 that I last saw him alive on Dec 9 1940  
 and that death occurred on the date and hour stated above.

8. AGE: Years 8 Months 10 Days \_\_\_\_\_  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Croupous Pneumonia 8 days  
 Duration \_\_\_\_\_

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

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 12. Name Clarence Roberts  
 13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Stacy Lewis  
 15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER  
 16. (a) Informant C. M. Patrick  
 (b) Address Spokane, Mo.  
 17. (a) Burial (b) Date thereof Dec. 11-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Spokane Cem.  
 18. (a) Signature of funeral director J. W. Maple  
 (b) Address Clever, Mo.  
 19. (a) 1-1-1941 (b) Luella Leonard  
(Date received local registrar) (Registrar's signature)

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 J. S. Skumate (M. D. or other) 0  
 Address Peabo Spring Mo Date signed 12/10/40

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

RECEIVED

District Health Officer No. 6,

District File Number 341-488

Date Filed MAR 20 1911

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**