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FILED JUN 22 1944

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Jackson City, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Chapman's Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
In this community 6-6-44 to 6-9-44
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Moberly Mo
(If outside city or town limits, write "RURAL")
(d) Street No. R.R. # 3
(If rural, give location)
(e) Citizen of foreign country? f (Yes or No)
If yes, name country: -

3. (a) PRINT FULL NAME Wilma Mae Roberts

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex F 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 alive _____ years (Day) (Year)

7. Birth date of deceased may 3 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 1 6 hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name William Mitchell Roberts

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

14. Maiden name Mary Frances McDonald

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

16. (a) Informant Mary Roberts

(b) Address Moberly, Mo

17. (a) Removal (b) Date thereof 6-9-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly, Mo

18. (a) Signature of funeral director Snow Funeral Home
(b) Address Moberly, Mo

19. (a) 6-9-44 (b) D. E. Brown
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9
year 1944 hour 7 minute 50 A.M.

21. I hereby certify that I attended the deceased from June 6
1944 to June 9 1944
that I last saw her alive on June 9 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition
Duration one 2-3
months

Due to _____
Due to 200 w

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?
(Specify type of place) _____
(e) Means of injury _____

23. Signature W. M. Kelly (M. D. or other) _____
Address 1624 Pine Date signed 6-9-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.