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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22709**

FILED JUN 19 1944
Registration District No. **387**

Primary Registration District No. **6182**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Cora R.F.D. Pleasant Hill
(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 1
(Specify whether _____)

In this community lifetime
years, months or days

3. (a) PRINT FULL NAME: Donaldald 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 single
0 divorced

6. (b) Name of husband or wife: _____

6. (c) Age of husband or wife if 25 years

7. Birth date of deceased: May 25, 1944
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 32 hr. - min.

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

10. Usual occupation: _____

11. Industry or business: _____

MOTHER FATHER { 12. Name: Agnes J. Roberts

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

14. Maiden name: Bessie Harlan Campbell

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

16. (a) Informant: Mrs. D. P. Plinstead

(b) Address: Pollock, Mo.

17. (a) Burial (b) Date thereof: May 27, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Bairdwood Cem. Miller

18. (a) Signature of funeral director: Schoenke & Schaefer

(b) Address: Milan, Mo. Frank Schaefer

19. (a) June 5-44 (b) Mrs. D. D. Green
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan

(c) City or town Cora Rural Pleasant Hill
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 115

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26 1944
year 9 hour _____ minute A.M.

21. I hereby certify that I attended the deceased from May 25, 1944, to May 26, 1944
that I last saw him alive on May 25, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Congestive Debility

Duration: _____

Due to: _____

Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

15/8

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: _____

Where did injury occur? _____ (City or town) (County) (State)

(c) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

(d) Means of injury: _____

23. Signature: E. W. Simpson (M. D. or other) OO
Address: Pollock Date signed: 5-27-44

1190

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 6-44-1195

Date Filed JUN 16 1944

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.....

Not embalmed

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

working under my personal supervision.

Signed *Frank Schoene*

Licensed Embalmer No. 2016

P. O. Address Milan Mo

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.