

FILED FEB 11 1946 STANDARD CERTIFICATE OF DEATH
State File No. **3102**Registration District No. **167**Primary Registration District No. **4256**Registrar's No. **62****1. PLACE OF DEATH:**

(a) County **Johnson**
 (b) City or town **Holden**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
South Market Street /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **none**
 (Specify whether
 In this community **80 years**
 years, months or days)

3. (a) PRINT FULL NAME **Mary Frances Lane Roberts**

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

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
 6. (b) Name of husband or wife **James W. Roberts** 6. (c) Age of husband or wife if alive **dec'd** years
 7. Birth date of deceased **January 25, 1859**
 (Month) (Day) (Year)

8. AGE: Years **86** Months **11** Days **17** If less than one day
 hr. min.

9. Birthplace **Macon County, Missouri.** (City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business **same**

MOTHER FATHER { 12. Name **James B. Lane**
 13. Birthplace **Kentucky** (City, town, or county) (State or foreign country)
 14. Maiden name **Rebecca Warford**
 15. Birthplace **Kentucky** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. G. V. Redford**
 (b) Address **Holden, Missouri**
 17. (a) **Burial** (b) Date thereof **Jan. 13-1946**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Holden, Missouri**
 18. (a) Signature of funeral director **Canaday & Ropp**
 (b) Address **Holden, Missouri**

19. (a) **2-1-46** (b) **Mrs G V Redford**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

Missouri Johnson
 (a) State (b) County
 (c) City or town **Holden**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **South Market Street.** (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country **XXXX**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **12**
 year **1946** hour **1:45** minute **A. M.**
 21. I hereby certify that I attended the deceased from **July 5**, 19**44**, to **Jan 12**, 19**46**
 that I last saw her alive on **Jan 10**, 19**46**
 and that death occurred on the day and hour stated above.

Immediate cause of death **Chronic Myocarditis** Duration

Due to
 Due to
 Other conditions **Hypostatic Pneumonia**
 (Include pregnancy within months of death)
 Major findings: **following Fractured Hcp**
 Of operations
 Of autopsies

PHYSICIAN
 Underline the cause to which death should be charged statistically.
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **51**
 (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 **Kelly Rawlins** (M. D. or other)
 Address **Holden, Mo** Date signed **1/14/46**

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 M. L. Canavan

Licensed Embalmer No. 3434

P. O. Address Holden, ma

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 167

Primary Registration District No. 4256

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Holden
(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 _____ years, months or days

3. (a) PRINT FULL NAME Mary F.L. 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 wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 25 (Month) 1905 (Day) 1905 (Year)

8. AGE: Years 86 Months _____ Days _____ If less than one day _____ hr. _____ min. mo

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

MOTHER FATHER

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1944 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 _____

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) accident

(b) Date of occurrence July 4, 1944

(c) Where did injury occur? Holden Johnson Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home in yard

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

23. Signature Kelly Rawlins (M. D. or other) _____

Address Holden Mo. Date signed 2/14/46

SUPPLEMENTARY

1450

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

3102