

S. No. 2
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7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 4 1947

Registration District No. 322

Primary Registration District No. 3071

Registrar's No.

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Slater
(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. 40 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Miss Elwood Roberts

3. (b) If veteran, name war: _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race W.

6. (a) Single, widowed, married, divorced Single

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

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

7. Birth date of deceased: Aug. 28, 1877
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>5</u>	<u>23</u>	hr. _____ min.

9. Birthplace New Buffalo Michigan
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name H. H. Roberts Roberts

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

14. Maiden name Don't know

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sadie Turk

(b) Address Slater Mo.

17. (a) Burial (b) Date thereof Feb. 23-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Slater Cemetery Jones and Salzer

18. (a) Signature of funeral director Slater Missouri.

(b) Address _____

19. (a) Feb. 25, 1947 (b) Mrs. Earl C. Metz
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline 97

(c) City or town Slater 2
(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 Feb. 21, 1947
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 1946, to Feb - 21 -, 1947
that I last saw her alive on Feb - 21 -, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Terminal cause of apoplexy. Low blood

Due to: Diabetes

Due to: _____

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

Major findings: _____

Of operations: Col.

Of 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? _____

While at work? _____ (Specify type of place)

(e) Means of injury Car

23. Signature M. C. Higgins M.D.
Address Slater Date signed 2/22/47

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

17
2
1

Cochran

3-47

MAR 4 1961

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 *James E. Jones*
Licensed Embalmer No. *3143*
P. O. Address. *Slater Missouri.*

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.