

Registration District No. **128** Primary Registration District No. **544d**

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

1. PLACE OF DEATH:

(a) County **GREENE**

(b) City or town **Rural, Campbell Twp., SOUTH**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Springfield R.F.D. # 9
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **32 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**

(c) City or town **Rural - Springfield**
(If outside city or town limits, write "RURAL")

(d) Street No. **Springfield R.F.D. # 9**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Mary Dora Roberts**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **13th** year **1947** hour **4:30** A.M. minute _____ M.

21. I hereby certify that I attended the deceased from **April 10**, 19**47**, to **Aug 12**, 19**47**, that I last saw her alive on **Aug 12**, 19**47**, and that death occurred on the date and hour stated above.

4. Sex **Female** **5. Color or race** **White**

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

6. (b) Name of husband or wife **George Roberts**

6. (c) Age of husband or wife if alive **80** years

7. Birth date of deceased **September 19, 1870**
(Month) (Day) (Year)

Immediate cause of death **Cardiac failure** Duration **1 Wks.**

Due to **Cardiovascular renal disease** **5 yrs**

Due to _____

8. AGE:	Years	Months	Days	If less than one day
	76	10	24	_____ hr. _____ min.

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

Major findings: **938**

Of operations _____

Of autopsy _____

9. Birthplace **Shreveport, Louisiana**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business **House wife**

12. Name **Issac Gunn**

13. Birthplace **unknown Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **unknown**

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant: **George Roberts**

(b) Address **R.F.D. # 9, Springfield, Mo.**

17. (a) Burial **(b) Date thereof** **Aug. 15, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Roberts Cemetery**

18. (a) Signature of funeral director **Fred C. Thieme**

(b) Address **Springfield, Mo.**

19. (a) 8-14-47 **(b) W E Handley M.D.**
(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 **L. M. R...** (M. D. or other) **M.D.**
Address **Woodhull Rd., Springfield** **Date signed** **8/13/47**

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 Ralph H. Thiem
Licensed Embalmer No. 3689
P. O. Address Springfield, 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.