

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1

FILED DEC 17 1947

Registration District No. 192

Primary Registration District No. 4305

Registrar's No. 31

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

1. PLACE OF DEATH:

(a) County McDonald

(b) City or town Anderson  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
E. side of Anderson on Hy. 44  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether in this community 18 months years, months or days)

3. (a) PRINT FULL NAME Sarah Kennedy Roberts

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Walter Henry Roberts

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

7. Birth date of deceased October 11, 1882  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>0</u>	<u>13</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name David Kennedy

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

14. Maiden name unknown

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

16. (a) Informant Miss. Marion Roberts

(b) Address Anderson, Mo.

17. (a) Burial (b) Date thereof 10-26-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address Cassville, Mo.

19. (a) 12-10-47 (b) Virginia Bueck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24  
year 1947 hour 3:35 minute A M.

21. I hereby certify that I attended the deceased from October 23<sup>rd</sup> 1947 to Oct 24<sup>th</sup> 1947 1947  
that I last saw her alive on October 24<sup>th</sup> 47 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Arterio-sclerosis

Duration  
6 hours

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? (e) Means of injury \_\_\_\_\_

23. Signature W. B. B. D. (M. D. or other) \_\_\_\_\_  
Address Anderson Mo Date signed 11/5/47

**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: \_\_\_\_\_

*W. C. Koon*

Licensed Embalmer No. \_\_\_\_\_

*4359*

P. O. Address \_\_\_\_\_

*Cassville, 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.**