

No. 2  
2-43  
17-39  
X35697

FILED MAR 16 1948

Registration District No. 270

Primary Registration District No. 3050

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Pemiscot

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

(c) Name of hospital or institution: East 10th St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 7 Years.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot 78

(c) City or town Caruthersville, 1  
(If outside city or town limits, write "RURAL")

(d) Street No. East 10th St., 2  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Earl D. Roberson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8th  
year 1948 hour 1 minute \_\_\_\_\_ P. M.

4. Sex Male 5. Color or race White 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 April 11 1927  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March, 7, 1948, to March 8, 1948, that I last saw him alive on March 8, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death: Congenital Heart Disease Duration \_\_\_\_\_  
Patent Foramen Ovale 20yr.

8. AGE: Years Months Days If less than one day  
20 10 28 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

Major findings: \_\_\_\_\_

Of operations: None

Of autopsy: None

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

10. Usual occupation Radio operator

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name John Roberson

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

14. Maiden name Marie Woods

15. Birthplace Rockwood, Ill. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Marie R. Brown

(b) Address Caruthersville, Mo.

17. (a) Burial (b) Date thereof 3-10-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Prairie Cem.

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? \_\_\_\_\_

18. (a) Signature of funeral director LaForge Und. Co.

(b) Address Caruthersville, Mo.

19. (a) 3-12-48 (b) Frederic B. Nichols  
(Date received local registrar) (Registrar's signature) (1-1-48)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury 0

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address Caruthersville, Mo. Date signed 3/8/48

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

3-48-86

MAR 26 1986

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.....

*Boyd B. Willis*, Registered Apprentice No. *19*  
working under my personal supervision.

Signed *Noel C. Seave*

Licensed Embalmer No. *3941*

P. O. Address... *Canthamville*

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
19  
Registrar's No. \_\_\_\_\_

Registration District No. 0270

Primary Registration District No. 3050

1. PLACE OF DEATH:

(a) County Pemisco

(b) City or town Caruthersville  
(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 Earl O. Roberson

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

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

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced 3

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased April 11 1922  
(Month) (Day) (Year)

8. AGE: Years 20 Months 10 Days \_\_\_\_\_ (If less than one day, \_\_\_\_\_ min.)

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

10. Usual occupation Auto Operator

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

MOTHER FATHER { 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 \_\_\_\_\_  
(Burial, cremation, or removal) (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 April year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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

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

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

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-2623