

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8061**
Registrar's No. **257-A**

FILED MAR 22 1952

REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Republic 0290	
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital		d. STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED a. (First) William		b. (Middle) A.	
c. (Last) Roberts		4. DATE OF DEATH (Month) (Day) (Year) March 11 1952	
5. SEX Male		6. COLOR OR RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Sept. 20 1897	
9. AGE (In years last birthday) 54		10. MONTHS 5	
11. DAYS 0		12. HOURS 0	
13. MIN. 0		10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Minister	
10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.		13a. FATHER'S NAME Joseph Roberts	
13b. MOTHER'S MAIDEN NAME Mary E. Newberry		14. NAME OF HUSBAND OR WIFE Ruth M. Roberts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY (If yes, give war or dates of service) 487-28-6188	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Ruth Roberts		ADDRESS Republic, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) INTRACRANIAL HEMORRHAGE <i>(Paralysis of respiratory center)</i> DUPEXTENSION <i>a few yrs</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intra cranial Hemorrhage ANTECEDENT CAUSES (Paralysis of respiratory center) DUE TO (b) Dupextension DUE TO (c) a few yrs	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/11 1952 to 3/11 1952 , that I last saw the deceased alive on 3/11 1952 , and that death occurred at 3:52 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Ray D. Callaway M.D.		23b. ADDRESS Springfield Mo	
(Degree or title)		23c. DATE SIGNED 3/11/52	
24a. BURIAL / CREMATION REMOVAL (Specify) Burial		24b. DATE March 14, 1952	
24c. NAME OF CEMETERY OR CREMATORY Keweenaw		24d. LOCATION (City, town, or county) (State) Republic, Mo.	
DATE REC'D BY LOCAL REG. 3-17-52		REGISTRAR'S SIGNATURE James H. Amos M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Wood. Forett		ADDRESS Republic, Mo.	

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed *John McTalb*

Signed _____
Student Embalmer

Licensed Embalmer No. 4635

P. O. Address Republic, 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.