

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **298**

FILED FEB 1 1954

BIRTH NO. 87258-53 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 70

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	
c. LENGTH OF STAY (in this place) <u>Life</u>		d. STREET ADDRESS (If rural, give location) <u>2507 Cedar St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Gen. Osteopathic Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>DEBORAH</u> b. (Middle) <u>LYNN</u> c. (Last) <u>ROBERTS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 16, 1954</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	
8. DATE OF BIRTH <u>Dec. 29, 1953</u>		9. AGE (In years last birthday) <u>18</u>		IF UNDER 1 YEAR: Months <u>18</u> Days <u>18</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Joseph, Mo.</u>	
12. COUNTRY OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>Russell Roberts</u>		13b. MOTHER'S MAIDEN NAME <u>Mabel M. Liddett</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Russell Roberts, 2507 Cedar St., City</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia Lobar</u> ANTECEDENT CAUSES DUE TO (b) <u>Cold</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	------------------------------------------------------------------------

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			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 Jan 14, 1954, to Jan 16, 1954, that I last saw the deceased alive on Jan 16, 1954, and that death occurred at 8:40A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>C. L. Ferguson, M.D.</u>		23b. ADDRESS <u>801 1/2 Francis St., City</u>		23c. DATE SIGNED <u>1-19-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 18, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>					

DATE REC'D BY LOCAL REG. <u>Jan 25, 1954</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Rupp</u>	
				ADDRESS <u>St. Joseph, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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.

Student
Student Embalmer

Signed

Albin C. Bazan

Licensed Embalmer No.

4795

P. O. Address

St. Joseph, 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.