

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8366**

FILED MAR 19 1954

BIRTH NO. _____ REG. DIST. NO. **132** PRIMARY REG. DIST. NO. **5469** Registrar's No. **30**

1. PLACE OF DEATH a. COUNTY GRUNDY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY GRUNDY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL FRANKLIN TOWNSHIP		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) FRANKLIN TOWNSHIP	

3. NAME OF DECEASED (Type or Print) a. (First) SILVA b. (Middle) AMY c. (Last) ROBERTS			4. DATE OF DEATH (Month) (Day) (Year) FEB 15 1954			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY-22-1901	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MO. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME WILLIAM BOSLEY		13b. MOTHER'S MAIDEN NAME MARY STANTURF		14. NAME OF HUSBAND OR WIFE IRVAN ROBERTS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS IRVAN ROBERTS Spickard MO.	

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		INTERVAL BETWEEN ONSET AND DEATH about 1 yr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of ovaries		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION July-1953		19b. MAJOR FINDINGS OF OPERATION Carcinoma of both ovaries		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		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 **May**, 1953, to **Feb 15**, 1954, that I last saw the deceased alive on **Feb 12**, 1954, and that death occurred at **1:15 A.** m., from the causes and on the date stated above.

23a. SIGNATURE H. Muller, M.D. (Degree or title)		23b. ADDRESS Preston, Mo.		23c. DATE SIGNED 2-15-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE FEB 17 1954		24c. NAME OF CEMETERY OR CREMATORY MASONIC CEM.	
		24d. LOCATION (City, town, or county) (State) Spickard MO.			

DATE REC'D BY LOCAL REG. 2-17-1954		REGISTRAR'S SIGNATURE Edgar G. Bridger		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS SCHOOLER FUNERAL HOME Spickard MO.	
---	--	---	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

400
1

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 Ross Wise

Licensed Embalmer No. 3771

P. O. Address Spickard 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.