No. 300
10-48

FILED MAY 5 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11408

BIRTH NO. _____ REG. DIST. NO. 49 PRIMARY REG. DIST. NO. 5175 Registrar's No. ~~49~~ 5

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

1. PLACE OF DEATH
a. COUNTY: Camden
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Russel Township
c. LENGTH OF STAY (In this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Own Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Camden
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Macks Creek
d. STREET ADDRESS (If rural, give location): Gen Del

3. NAME OF DECEASED (Type or Print)
a. (First): Eber
b. (Middle): Ray Rooffener
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): April 15 - 1954

5. SEX: male
6. COLOR OR RACE: wht
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 6-18-1910
9. AGE (In years last birthday): 43 — IF UNDER 1 YEAR: Months 9, Days 28 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farming
10b. KIND OF BUSINESS OR INDUSTRY: Agri
11. BIRTHPLACE (City and State or Foreign Country): Camden Co. Mo
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Joseph Rooffener
13b. MOTHER'S MAIDEN NAME: Delia Jackson
14. NAME OF HUSBAND OR WIFE: Goldie Meads

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 491-12-2411
17. INFORMANT'S SIGNATURE OR NAME: Mrs Ray Rooffner — ADDRESS: as above

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid 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
19b. MAJOR FINDINGS OF OPERATION: 331 X
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1954, *to* Apr 14, 1954, *that I last saw the deceased alive on* Apr 14, 1954, *and that death occurred at* 6 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. E. Chaibour M.D.
23b. ADDRESS: Camdenton Mo
23c. DATE SIGNED: 4-16-54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 4/18/54
24c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove
24d. LOCATION (City, town, or county) (State): Camden Co Mo

DATE REC'D BY LOCAL REG.: April 30
REGISTRAR'S SIGNATURE: Alda R. Eldred 484
25. FUNERAL DIRECTOR'S SIGNATURE (ADDRESS): Bankson-Woolery Camdenton Mo

(Licensed Embalmer's Statement on Reverse Side)

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 Abbie Bankson Woolery

Licensed Embalmer No. 2488

P. O. Address Camden Me

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.