S. No. 300
v. 10.48

0470
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FILED FEB 21 1955

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 8059

BIRTH NO. _____ REG. DIST. NO. 144 PRIMARY REG. DIST. NO. 4234 Registrar's No. 8

1. PLACE OF DEATH
a. COUNTY: Iron
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ironton
c. LENGTH OF STAY (In this place): 2Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Iron
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ironton
d. STREET ADDRESS (If rural, give location): General Delivery 0470 0

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) Ase c. (Last) Roberson

4. DATE OF DEATH: (Month) 2 (Day) 5 (Year) 55

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: 12/12/1873

9. AGE (In years last birthday): 81 — 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): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Labor

11. BIRTHPLACE (City and State or Foreign Country): Coffman Mo

12. CITIZEN OF WHAT COUNTRY?: Us.A.

13a. FATHER'S NAME: Unk

13b. MOTHER'S MAIDEN NAME: Unk

14. NAME OF HUSBAND OR WIFE: Mary A. Roberson Decease

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S SIGNATURE OR NAME: Personal Papers ADDRESS

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: 0

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Arterio-Sclerosis — ?

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* 2-5, 1952, *to* 2-5, 1955, *that I last saw the deceased alive on* 2-2, 1955, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): George M. Gayle M.D.

23b. ADDRESS: Ironton Mo

23c. DATE SIGNED: 2-10-55

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 2/11/55

24c. NAME OF CEMETERY OR CREMATORY: Pilot Knob Cemetery

24d. LOCATION (City, town, or county) (State): Pilot Knob Missouri.

DATE REC'D BY LOCAL REG.: 2-11-55

REGISTRAR'S SIGNATURE: Mrs Avis Jones 128-0

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Howell Funeral Home Ironton Mo

(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 C. A. Howell

Licensed Embalmer No. 3670

P. O. Address Trenton, 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.