

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 18 1956

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>5</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kirkbarrille</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Slater</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Laughlin Hosp. &amp; Clinic</u>				STREET ADDRESS (If rural, give location) <u>0971</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Roberta</u>		b. (Middle) <u>ELIZA</u>		c. (Last) <u>SOPER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 10, 1956</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>April 7, 1875</u>	
9. AGE (In years last birthday) <u>80</u>		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Saline Co. Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Robert Soper</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Ann Allen</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mildred Soper, Slater, Mo</u> 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>PROGRESSIVE CEREBRAL THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>DEBILITATION FOLLOWING SURGERY</u>					
		DUE TO (c) <u>ADENOCARCINOMA SIGMOID COLON - DIABETES - NEPHRITIS</u>				UNKNOWN	
19a. DATE OF OPERATION <u>11-20-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>PARTIAL COLECTOMY SIGMOID COLON 153X</u>				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) _____		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 <u>Nov 27</u> 19 <u>55</u> , to <u>JAN 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JAN 9</u> , 19 <u>56</u> and that death occurred at <u>7:30</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Carl Laughlin, M.D.</u> (Degree or title)				23b. ADDRESS <u>So. Kirkbarrille, Mo</u>		23c. DATE SIGNED <u>1-10-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1-12-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Slater Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Slater Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1-10-56</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jones Funeral Home, Slater, Mo.</u> ADDRESS _____			

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

EXHIBIT 7000

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.....  
Signature of Student Embalmer

Signed *Robert B. Harris*

Licensed Embalmer No. *421*

P. O. Address *Kirkland*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.