

Health, Welfare, Public Service, 100-56, Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms which are not diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JAN 21 1957

STANDARD CERTIFICATE OF DEATH

1052

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 5766 Registrar's No. 64

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Greene				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Campbell Township		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY, OR TOWN Campbell Township R. #9, Springfield, Mo.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION R. #9		Length of stay in 1b 89 yrs.		d. STREET ADDRESS R. #9,		(If outside, give location) 0546 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First GEORGE Middle GRANT Last ROBERTS				4. DATE OF DEATH Month Jan. Day 17, Year 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1867		9. AGE (In years last birthday) 89	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) Greene County, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Roberts				14. MOTHER'S MAIDEN NAME Nancy Jennings				
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. none		17. INFORMANT Address MO. Mrs. Carrie Moses R. #9, Springfield				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis							INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to above - cause (a), stating the underlying cause last. DUE TO (b) Arterio sclerosis								
DUE TO (c) Senility								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from Jan - 1949 , to Jan. 17, 1957 and last saw him him alive on Jan 16 57 Death occurred at 3:00 P. m on the date stated above; and to the best of my knowledge from the causes stated.								
21a. SIGNATURE L. M. Reigney, M.D. (Degree or title)				22b. ADDRESS 331 St. Louis Springfield, Mo		22c. DATE SIGNED 1-18-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 20, 1957	23c. NAME OF CEMETERY OR CREMATORY Roberts Cemetery		23d. LOCATION (City, town, or county) (State) Greene Co. Mo.			
24. FUNERAL DIRECTOR ADDRESS Ralph Thieme Springfield, Mo.			25. DATE RECD. BY LOCAL REG. 1-18-57		26. REGISTRAR'S SIGNATURE Earth Williamson			

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.....
Lee Mason

Licensed Embalmer No. 4568

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.