

Health, Welfare & Public Service

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ALL diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JAN 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **3482**

Registration District No. **360** Primary Registration District No. **3076** Registrar's No. **17**

1. PLACE OF DEATH a. COUNTY Vernon			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Barton		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Nevada		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Warsaw		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 507 S. Cedar		Length of stay in lb 8 Yrs.	d. STREET ADDRESS (If outside, give location) 1		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Calvin Middle Last Roberts			4. DATE OF DEATH Month Jan. Day 14 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 19 July 1876	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and state or country) Crosstimbers, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Jess B. Roberts			14. MOTHER'S MAIDEN NAME Nettie Carly		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Records of the Anderson Nursing Home, Nevada, Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion					INTERVAL BETWEEN ONSET AND DEATH 3 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <input checked="" type="checkbox"/> DUE TO (c) <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Third degree burn from falling on gas stove					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) Elderly man fell on gas stove				4201F
20c. TIME OF INJURY. Hour 12:00 Month Nov. Day 1 Year 1957	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home		20f. CITY, TOWN, OR LOCATION Nevada COUNTY Vernon STATE Mo.	
21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at Dead on arrival m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Robert H. Water (Degree or title)			22b. ADDRESS Nevada - Mo.		22c. DATE SIGNED 1-15-57
23a. BURIAL OR CREMATION DATE Removal 1-15-'57		23b. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Warsaw Mo.	
24. FUNERAL DIRECTOR Lucian - Carothers - El Dorado Sp. Co.		25. DATE RECD. BY LOCAL REG. 1-19-1957		26. REGISTRAR'S SIGNATURE Anna E. Perry	

(Licensed Embalmer's Statement on Reverse Side)

8708

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed... *May W. Seckering*

Licensed Embalmer No. *469*

P. O. Address *E. David*

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.