

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3979

FILED FEB 25 1957

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3009 Registrar's No. 143

Health,
Welfare
Public
Service

300
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | |
|---|--|---|---|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson MO</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Jackson MO</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>220 Cherry St. St. Luke's</u> | | | | Length of stay in lb | | d. STREET ADDRESS (If outside, give location) <u>220 Cherry St.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Emilia</u> Last <u>Roboff</u> | | | | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1957</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 14 - 1882</u> | |
| 9. AGE (In years last birthday) <u>74</u> | | IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. | | 10. KIND OF BUSINESS OR INDUSTRY <u>Housewife Keeping House</u> | | 11. BIRTHPLACE (City and state or country) <u>Missouri</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, seen if retired) <u>Housewife</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>August Rose</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Louise Bartels</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Albert Roboff Jackson Mo</u> Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | DUE TO (b) _____ |
| DUE TO (c) _____ | | | | | | | |
| 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"/> |
| 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.) <u>153x</u> | | | | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____ | | | | | | | |
| 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 <u>May 1956</u> to <u>Feb. 18, 1957</u> and last saw her alive on <u>Feb. 17, 1957</u> Death occurred at <u>11:40 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>J. N. Jaeger M.D.</u> (Degree or title) | | | | 22b. ADDRESS <u>Jackson, Mo.</u> | | 22c. DATE SIGNED <u>2-19-57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIUM | | 23d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Feb. 20-57</u> | | <u>Russell Heights</u> | | <u>Jackson MO</u> | |
| 24. FUNERAL DIRECTOR <u>Denette Laird Jackson mo</u> ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. <u>2-21-1957</u> | | 26. REGISTRAR'S SIGNATURE <u>C. C. Summers</u> | |

(Licensed Embalmer's Statement on Reverse Side)

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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 *R. C. Land*

Licensed Embalmer No. *45*

P. O. Address *Jackson*

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.