

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-022745
STATE FILE NUMBER

FILED JUN 18 1958 Registration District No. 264 Primary Registration District No. 5899 Registrar's No. 27

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Ozark</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ozark</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Celijah</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Celijah</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>0770</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Tom</u> Middle <u>T.</u> Last <u>Roberts</u>			4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>58</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1894</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Submilliner</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>	9c. AGE (In years last birthday) <u>63</u>
10a. FATHER'S NAME <u>A. F. Roberts</u>		10b. MOTHER'S MAIDEN NAME <u>Frankie Taylor</u>	10c. NAME OF HUSBAND OR WIFE <u>Maggie Roberts</u>
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WWI</u>		12. SOCIAL SECURITY NO. <u>None</u>	13. INFORMANT <u>Maggie Roberts</u> Address <u>Celijah, Mo.</u>
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>DIABETES Mellitus</u>			15. INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
16. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>		17. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>---</u>	
18. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		19. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>---</u>	
20. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21. CITY, TOWN, OR LOCATION COUNTY STATE <u>---</u>	
22. I attended the deceased from <u>May 24, 1958</u> and last saw him <u>alive on May 28, 1958</u> Death occurred at <u>about 3 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
23. SIGNATURE (Degree or title) <u>Jack McWilliams</u>		24. ADDRESS <u>West Plains, Mo.</u>	
25. DATE SIGNED <u>6-6-58</u>		26. DATE OF BIRTH <u>7-24-1894</u>	
27. BURIAL, CREMATION, REMOVAL (Specify) <u>13</u>		28. DATE <u>5-31-58</u>	
29. NAME OF CEMETERY OR CREMATORY <u>Celijah Cemetery</u>		30. LOCATION (City, town, or county) (State) <u>Celijah Mo.</u>	
31. FUNERAL DIRECTOR <u>Robertson's West Plains, Mo.</u>		32. ADDRESS <u>---</u>	
33. DATE RECD. BY LOCAL REG. <u>6-14-58</u>		34. REGISTRAR'S SIGNATURE <u>Frank Mahan</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. may use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

REC'D JUN 20 1958
JUN 18 1958

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 *D. Robertson*

Licensed Embalmer No. *3432*

P. O. Address

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.