

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038915  
STATE FILE NUMBER

FILED DEC 9 1958

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 49

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Centralia</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>308 West Sneed</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>308 W. Sneed</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>---</u> Last <u>Roberts</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</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>Jan. 5, 1890</u>	9. AGE (In years or birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>29</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Taylor Hulen Roberts</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Viola Roberts</u>		14. NAME OF HUSBAND OR WIFE <u>Frances Maude Roberts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>495-34-3256</u>	17. INFORMANT Address <u>Mrs. Bernard Roberts, Centralia, Mo.</u>		
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>Cerebral Artery Thrombosis involving Respiratory Center, 24hours Cerebral Acute Sclerosis</u> DUE TO (b) <u>General Acute Sclerosis</u> DUE TO (c) <u>Osteo Arthritis, Severe and Benign Prostectic</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertrophy</u>					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.)			
20c. TIME OF INJURY Hour . Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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>7/23/55</u> to <u>12/3/58</u> and last saw her/him alive on <u>12/3/58</u> Death occurred at <u>2: p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Edw. L. Ward MD</u>			22b. ADDRESS <u>120 N. Rollins, Centralia, Missouri</u>		22c. DATE SIGNED <u>12/5/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<u>Burial</u>		<u>Dec. 7, 1958</u>	<u>Centralia</u>		<u>Centralia, Mo.</u>
24. GENERAL DIRECTOR'S ADDRESS <u>Dale Co. Meado Centralia, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 6. 1958</u>	26. REGISTRAR'S SIGNATURE <u>Maud Mc Bride</u>		

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

30

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 Bill J. Meador  
Licensed Embalmer No. 4576  
P. O. Address Antelope, Missouri

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.

DEC 11 1958