

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001765  
STATE FILE NUMBER

FILED FEB 11 1959 Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 35

300  
1-57

|   |                           |   |   |   |   |
|---|---------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY Jasper   |                           |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Jasper |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Carthage   |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN Carthage 0493   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br>803 E. 3rd  |                           | Length of stay in 1b<br>19 yrs  | d. STREET ADDRESS (If outside, give location)<br>803 E. 3rd St  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                        |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br>Rev. JEFFERSON F. ROBERTS  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>Feb. 1, 1959  |   |   |
| 5. SEX<br>male 2  | 6. COLOR OR RACE<br>Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Jan. 7, 1885  | 9. AGE (In years last birthday)<br>74                 | 10. F UNDER 1 YEAR<br>Months Days   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Baptist Minister   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>religion   | 11. BIRTHPLACE (City and state or country)<br>Texas   |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |
| 13a. FATHER'S NAME<br>Jeff Roberts  |                           | 13b. MOTHER'S MAIDEN NAME<br>unknown  |   | 14. NAME OF HUSBAND OR WIFE<br>Myrtle Stinson Roberts |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>no  |                           | 16. SOCIAL SECURITY NO.<br>none   | 17. INFORMANT<br>Address<br>Mrs. J.F. Roberts, 803 E 3rd, Carthage, Mo  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Coronary occlusion   |                           |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br>5 min   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)  |                           |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>4201   |                           |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>Hour Month, Day, Year<br>a.m.<br>p.m.  |                           |   |   |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 1-7-50 to Feb 1, 1959, and last saw him alive on 1-5-59<br>Death occurred at 1:15 a m on the date stated above; and to the best of my knowledge, from the causes stated. |                           |   |   |   |   |
| 22a. SIGNATURE (Deceased or wife)<br>M. Foster Witten MD  |                           |   | 22b. ADDRESS<br>Carthage, Mo  |   | 22c. DATE SIGNED<br>2-2-59  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                           | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City, town, or county) (State)   |
| burial  |                           | Feb 5, 1959   | Cedar Hill Cemetery   |   | Carthage, Mo  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Knell Mortuary, Carthage, Mo   |                           |   | 25. DATE RECD. BY LOCAL REG.<br>2-5-59  | 26. REGISTRAR'S SIGNATURE<br>E. W. Clutter            |   |

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

STATEMENT BY LICENSED EMBALMER

X 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. L. Isbell .....

Licensed Embalmer No. 4970 .....

P. O. Address Cartage, 9m .....

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.