

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-020779

REG JUL 13 1959 82

Registration District No. \_\_\_\_\_ Primary Registration District No. 3017 Registrar's No. 95

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Cooper</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville</u>		Length of stay in 1b <u>6 Weeks</u>		c. CITY OR TOWN <u>Wooldridge</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>304 McRoberts St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.F.D.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>Roberts</u> Last <u>Bruce</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</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>Nov. 25 1896</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Lafayette County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Dr. Walter Roberts</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Osborn.</u>			14. NAME OF HUSBAND OR WIFE <u>Hugh Bruce.</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>-----</u>		17. INFORMANT Address <u>Mrs. Lester Stock, Boonville, 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 Apoplexy</u> <u>Arterio Sclerosis</u> DUE TO (b) <u>Diabetes</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>Inst</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____							
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>Jan 1956</u> to <u>July 7 59</u> and last saw her <u>alive</u> on <u>July 2 59</u> Death occurred at <u>8:30</u> <u>9</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>M L Deelwaege</u> (Degree or title) <u>MD</u>				22b. ADDRESS <u>Boonville Mo</u>		22c. DATE SIGNED <u>7/8/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/9/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove Cemetery</u>		23d. LOCATION (City, town, or county) <u>Boonville, Mo.</u>			
24. FUNERAL DIRECTOR <u>Goodman &amp; Boller, Boonville, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>7/8/59</u>		26. REGISTRAR'S SIGNATURE <u>De Hooper</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF.

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William W. Wood

Licensed Embalmer No. 4539

P. O. Address Boonville, Mo

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.