RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 13 1959

59–031926

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 213

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY FRANKLIN
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON — Length of stay in 1b 4 HRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. FRANCIS HOSP — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ILLINOIS b. COUNTY MOULTRIE
c. CITY OR TOWN GAYS — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) R.R.I — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: ORVAL Middle: Last: ROBY
4. DATE OF DEATH Month: OCT. Day: 7 Year: 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: SEPT. 4, 1881
9. AGE (last birthday): 78 — 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): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (City and state or country): Shelby Co. Ill.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: William Roby
13b. MOTHER'S MAIDEN NAME: HARRIET McCRORY
14. NAME OF HUSBAND OR WIFE: EDITH WANGSTON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 330-32-7092
17. INFORMANT: HAROLD ROBY Address: GAYS, ILL.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture skull, cerebral laceration — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) and concussion, laceration
DUE TO (c) of aorta + other injuries — Celes
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☒ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Subject drove auto off
20c. TIME OF INJURY Hour a.m. p.m. 11:30 Month, Day, Year 10/7/59 highway falling roadside obstacle
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 66 near
20f. CITY, TOWN, OR LOCATION Sullivan COUNTY Franklin STATE Mo.

21. I attended the deceased from 10/7/59, to 10/7/59 and last saw her/him alive on 10/7/59
Death occurred at 5:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. O. Stewart (Degree or title) M.D. Coroner — 22b. ADDRESS Union Mo — 22c. DATE SIGNED 10/11/59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10-10-59
23c. NAME OF CEMETERY OR CREMATORY: BRANCHSIDE CEM.
23d. LOCATION (City, town, or county) (State): GAYS, ILLINOIS
24. FUNERAL DIRECTOR: BENJ. W. LOVINS — ADDRESS: WINDSOR, ILL.
25. DATE RECD. BY LOCAL REG.: 10/8/59
26. REGISTRAR'S SIGNATURE: F. E. Studmann

(Licensed Embalmer's Statement on Reverse Side)

NOV 13 1959

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_____ Signed Harrison T. Eaton

Signature of Student Embalmer

Licensed Embalmer No. 5066

P. O. Address Sulphur, Tex

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to cor
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.