

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-033218

FILED VS. SEP 28 1959 264

STATE FILE NUMBER

44

ENDED

1. PLACE OF DEATH a. COUNTY <u>Columb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Columb</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Elijah</u>		Length of stay in lb <u>Lifeline</u>	c. CITY OR TOWN <u>Elijah</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ashley</u> Middle <u>Frank</u> Last <u>Roberts</u>			4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-74</u>
9. AGE (last birthday) <u>85</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>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>W. Vernon, Kentucky</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>John Roberts</u>	
13b. MOTHER'S MAIDEN NAME <u>Ada Owens</u>		14. NAME OF HUSBAND OR WIFE <u>Frances Taylor 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>None</u>	17. INFORMANT <u>Tomer Roberts, Elijah, Missouri</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 thrombosis</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>Senility</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>10 years</u> <u>10 years</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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <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>1955</u> to <u>1959</u> and last saw him alive on <u>8/4/59</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M. L. Fowler M.D.</u> (Degree or title)		22b. ADDRESS <u>West Plains Mo</u>	22c. DATE SIGNED <u>8/24/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>8-20-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elijah Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Elijah, Missouri</u>
24. GENERAL DIRECTOR <u>Leland Carter</u> ADDRESS <u>West Plains Mo</u>	25. DATE RECD. BY LOCAL REG. <u>9-23-59</u>	26. REGISTRAR'S SIGNATURE <u>Thana Mahan</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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edward Carter

Licensed Embalmer No. 4516

P. O. Address West Plains

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.