S. No. 2
M—8-43
5-17-39
X37823

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 18 1944

Registration District No. 18

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33600

Primary Registration District No. 5043

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Seligman Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
In this community 15 years 1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Barry 5

(c) City or town Seligman 0
(If outside city or town limits, write "RURAL")

(d) Street No. Rural
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME IDA B. ROLLER

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female | 5. Color or race W | 6. (a) ~~Single~~, widowed, ~~married~~, divorced

6. (b) Name of husband or wife Henry Roller

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 4 (Month) 4 (Day) 1870 (Year)

8. AGE: Years 74 | Months 4 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Mo (City, town, or county) O (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name McConnack

13. Birthplace La. (City, town, or county) (State or foreign country)

14. Maiden name Dot Knotson

15. Birthplace — (City, town, or county) — (State or foreign country)

16. (a) Informant Ruby Wallace

(b) Address Cushing okla

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (Month) 7 (Day) 1944 (Year)

(c) Place: burial ~~or cremation~~ Roller Cemetery

18. (a) Signature of funeral director Culver Funeral Home

(b) Address Caswille missouri

19. (a) Aug 26-1944 (Date received local registrar) (b) Grace Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug day 5

year 1944 hour 8 minute a M.

21. I hereby certify that I attended the deceased from May 1, 1944, to Aug 5, 1944, that I last saw her alive on Aug 5 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemmahage	10 d
Due to: arteriosclerosis	
Due to: Edema	
Other conditions: Nephritis (Include pregnancy within 3 months of death)	

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature D W Edwards (M. D. or other)

Address Seligman Date signed 8/5/44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1044-1096
Date Filed OCT 30 1944

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed G. E. Culver

Licensed Embalmer No. 3584

P. O. Address Cassville

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 this body is not embalmed, fact should be so stated above.

S. No. 2B
0M—5-43
X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20

Registration District No. 11 Primary Registration District No. 5043 Registrar's No. 58

1. PLACE OF DEATH:
(a) County Barry
(b) City or town Sugar Creek Twp Seligman
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ida B. Keller
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years
7. Birth date of deceased April 4 1870 (Month) (Day) (Year)
8. AGE: Years 74 Months 4 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day
year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Cerebral hemmorrage (Duration)
Due to arteriosclerosis
Due to Edema
Other conditions Chronic nephritis
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

33600