

S. No. 2
M-5-43
5-17-39
I X38671

FILED SEP 23 1948
Registration District No. 2000

Primary Registration District No. 2000

Registrar's No. 725

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

1. PLACE OF DEATH:

(a) County GREENE

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

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

(d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days)

In this community 10 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Benton Co.

(c) City or town Seleigman #1
(If outside city or town limits, write "RURAL")

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

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

If yes, name country _____

3. (a) PRINT FULL NAME ANDREW WASHINGTON ROLLER

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1 year 1946 hour 1 minute 30 M.

21. I hereby certify that I attended the deceased from Aug 22 to Sept 1 1946 that I last saw him alive on Sept 1 1946 and that death occurred on the date and hour stated above.

Immediate cause of death uremia

Duration _____

4. Sex male race white

5. Color or race _____

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife UNK.

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

7. Birth date of deceased March 28, 1865
(Month) (Day) (Year)

Due to Suppression following Prostatology

Due to _____

Other conditions age (Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day

81 5 3 hr. min.

Major findings: Prostatic Hypertrophy

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

9. Birthplace UNK. no. 6
(City, town, or county) (State or foreign country)

10. Usual occupation Furniture mfg. & Finer

11. Industry or business _____

12. Name Jacob Roller

13. Birthplace UNK. UNK. 9
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Amhart

15. Birthplace UNK. UNK. 9
(City, town, or county) (State or foreign country)

16. (a) Informant Rupert W. Roller

(b) Address Seleigman, Mo.

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? _____

17. (a) Burial (b) Date thereof 9-3-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Roller Cemetery, Ark.

While at work? _____ (Specify type of place)

(c) Means of injury _____

18. (a) Signature of funeral director W. H. ...

(b) Address Springfield, Mo.

19. (a) 9-3-46 (b) W. H. Hardy, M.D.
(Date received local registrar) (Registrar's signature)

23. Signature W. H. Hardy (M. D. or other) M.D.

Address Springfield, Mo. Date signed 9-1-46

STATE OF MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL RECORDS
ST. LOUIS, MISSOURI

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 *Roy A. ...*
Licensed Embalmer No. *1763*

P. O. Address *Springfield*

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.