WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Daviess

Township or Village Jamesport

Registration District No. 252 File No. 626

Primary Registration District No. 5354 Registered No. One

or City _____ (NO. _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Inez Rosenbaum

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE / MARRIED / WIDOWED / OR DIVORCED (Write the word)

DATE OF BIRTH: June 8th, 1912 (Month) (Day) (Year)

AGE: 1 yrs. 7 mos. 11 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): Daviess Co Mo

PARENTS

NAME OF FATHER: W C Rosenbaum

BIRTHPLACE OF FATHER (City or town, State or foreign country): Daviess Co Mo

MAIDEN NAME OF MOTHER: Bessie Watkins

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Daviess Co 8

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W C Rosenbaum

(ADDRESS) Jamesport Mo

Filed Jan 28 1914 C G McKinley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan (Month) 19 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 11, 1914, to Jan 19, 1914, that I last saw her alive on Jan 19, 1914, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Lightning Stroke

79A

61

(Duration) ___ yrs. ___ mos. 5 ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) R. V. Thompson M. D.

1-21 1914 (Address) Jamesport Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Antioch

DATE OF BURIAL: Jan 20 1914

UNDERTAKER: J O Buren

ADDRESS: Jamesport Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County [illegible]

Township _____ or Village _____ or City _____ (NO. _____ St.: _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)
[illegible]		

DATE OF BIRTH _____ (Month) _____ (Day) 1 (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

BIRTHPLACE (City or town, State or foreign country) [illegible]

PARENTS
NAME OF FATHER [illegible]
BIRTHPLACE OF FATHER (City or town, State or foreign country) [illegible]
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 191__ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__ and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191__
UNDERTAKER	ADDRESS