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 Greene

Township N. Robberson

or

Village

or

City (NO. St.: Ward)

Registration District No. 324

Primary Registration District No. 5449

File No. 15896

Registered No. 5

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

FULL NAME Rosa Fanning

PERSONAL AND STATISTICAL PARTICULARS

SEX: Femal

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Mar (Month) 21 (Day) 1878 (Year)

AGE: 36 yrs. 2 mos. 7 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife

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

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

PARENTS

NAME OF FATHER: Lee A. Calvin

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

MAIDEN NAME OF MOTHER: Melissa Ellen Jamison

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Pike Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Presley

(ADDRESS) Brighton Mo.

Filed May 29 1914 A. E. Patter M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 28 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from May 22, 1914, to May 28, 1914, that I last saw her alive on May 28, 1914, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

aortic Stenosis

81

92A

139B (Duration) ... yrs. ... mos. ... ds.

Contributory (SECONDARY) Endometritis & Varitis

(Duration) 7 yrs. ... mos. ... ds.

(Signed) B. E. Taylor M. D.

May 28 1914 (Address) Brighton

*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: Brighton Cem

DATE OF BURIAL: May 29 1914

UNDERTAKER: Will Prater

ADDRESS: Pleasant Hope Mo

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

Revised United States Standard Certificate

PLACE OF DEATH

County.....

Township ..... or Village..... or City ..... (NO. .... St.; ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occurr hospital or inst give its NAME of street and nu

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

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) .....

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

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),

I HEREBY CERTIFY, that I attended deceased ....., 191...., to ....., 1 that I last saw h..... alive on ....., 1 and that death occurred, on the date stated above, at ..... The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

Contributory ..... (SECONDARY)

..... (Duration) ..... yrs. ..... mos. .....

(Signed) .....

....., 191.... (Address) .....

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIE RECENT RESIDENTS)

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

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

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 1
UNDERTAKER	**ADDRESS**