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

86

**PLACE OF DEATH**

County Berry

Township Offs Creek

or

Village

or

City (NO. , St.; Ward)

Registration District No. 36 File No.

Primary Registration District No. 5041 Registered No. 4

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

FULL NAME Andrew W. Roe.

**PERSONAL AND STATISTICAL PARTICULARS**

SEX M

COLOR OR RACE W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH ~~Jan~~ Oct 3 ~~10~~ 1835 ~~1917~~ (Month) (Day) (Year)

AGE 81 yrs. mos. ds.

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

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

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

BIRTHPLACE (City or town, State or foreign country) Tennessee

PARENTS

NAME OF FATHER William Roe

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

MAIDEN NAME OF MOTHER Dont Know

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E C Roe

(ADDRESS) Peirce City Mo

Filed 1-11- 1917 W. W. West REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Jan. 10, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 6, 1917, to Jan 10, 1917, that I last saw him alive on Jan 6, 1917, and that death occurred, on the date stated above, at 17 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

82A 97 64 (Duration) yrs. mos. 5 ds.

Contributory (SECONDARY) Arteria Sclerosis

8 (Duration) yrs. mos. ds.

(Signed) H. Ross Clark M. D.

Jan-10, 1917 (Address) Peirce City, 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 Mt Olive Cemetry

DATE OF BURIAL Jan 11, 1917

UNDERTAKER G. A. Bennett

ADDRESS Peirce City Mo.

## PLACE OF DEATH

County _____

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

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

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** _____

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.

### PERSONAL AND STATISTICAL PARTICULARS

| SEX | COLOR OR RACE | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH _____, 1_____
(Month) (Day) (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 _____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw b_____ 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<br>_____, 191____ |
|---|---|
| UNDERTAKER | ADDRESS |