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

Do not use this space.
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5-6 - 13.5

File No. 21336
Registered No. 2681

1. PLACE OF DEATH
County: Jackson
Township: Grand
City: K.C. Mo (No. 1511 Tracy St. Ward)
Registration District No.: 399
Primary Registration District No.: 1002

2. FULL NAME: Rosa Routh
(a) Residence. No. 1945 Lowndale St., W-10 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: George Routh
6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 16-1871
7. AGE: Years 56 Months 1 Days 17 If LESS than 1 day, ____ hrs. or ____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: E. S. Yater
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ky.
12. MAIDEN NAME OF MOTHER: Nancy Walkins
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo

14. INFORMANT: Nancy Walkins
(Address): Buckola Mo
15. FILED 7/5 1927 M. M. Crowe Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 3 1927
17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____, that I last saw h. alive on ____, 19____, and that death occurred, on the date stated above, at ____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic arterio-sclerosis
131
97 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Chronic Interstitial nephritis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? DOA
DID AN OPERATION PRECEDE DEATH? Date
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Elias Stephenson M. D.
7-3, 1927 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Shawnee Kan. DATE OF BURIAL: July 6 1927
20. UNDERTAKER: Rose & Co. ADDRESS: 13-49 Jackson

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.