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

Do not use this space. 35669

1926

JAN 7

1. PLACE OF DEATH

County Scott Registration District No. 807 File No. 119

Township Richland Primary Registration District No. 6070 Registered No.

City Sikeston (No. St. Ward)

2. FULL NAME Rosella Atchley

(a) Residence. No. 505 Northwest St., 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	MEDICAL CERTIFICATE OF DEATH
3. SEX: Female / 4. COLOR OR RACE: White / 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Child	16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 1 1927
5a. If Married, Widowed, or Divorced HUSBAND of (or) WIFE of	17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1927, to Nov 1, 1927, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 7 30 P m.
6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 31 1926	THE CAUSE OF DEATH* WAS AS FOLLOWS:
7. AGE: Years 1, Months 5, Days 1. If LESS than 1 day, ...hrs. or ...min.	Bronchial Pneumonia 107A
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work: Child. (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer	(duration) ✓ yrs. mos. ds. CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.
9. BIRTHPLACE (CITY OR TOWN) New Madrid Co (STATE OR COUNTRY) Mo	18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
PARENTS 10. NAME OF FATHER Roy Atchley	8 DID AN OPERATION PRECEDE DEATH? no. DATE OF
11. BIRTHPLACE OF FATHER (CITY OR TOWN) New Madrid Co (STATE OR COUNTRY) Mo	WAS THERE AN AUTOPSY? no. WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination. (Signed) H M Kendig, M.D
12. MAIDEN NAME OF MOTHER Bessie Evans	11/2, 1927 (Address) Sikeston Mo.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Arkansas	*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.
14. INFORMANT Roy Atchley (Address) Sikeston Mo	19. PLACE OF BURIAL, CREMATION, OR REMOVAL Big Ridge. DATE OF BURIAL Nov 2 1927
15. FILED 12/6 1927 M Bloss REGISTRAR	20. UNDERTAKER H J Welsh. ADDRESS Sikeston Mo

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.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Scott Registration District No. 821 File No. 119
Township Richland Primary Registration District No. 6070 Registered No.
City (No. St. Ward)

2. FULL NAME Rosella Atchley

(a) Residence. No. St., 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
F	W	S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 11/15/27 W E Dennis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 1 19 27

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: Primary Bronchial Pneumonia

100 a X

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) None

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? Date of
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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