

FEB 23 1928

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

Do not use this space.

2046

1. PLACE OF DEATHCounty HenryRegistration District No. 660Township CentralPrimary Registration District No. 5878City Den V. RockberryFile No. 2

Registered No. _____

St. _____ Ward _____

2. FULL NAME

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS**3. SEX**male**4. COLOR OR RACE**white**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)Dec 23, 1873**7. AGE**

YEARS

MONTHS

DAYS

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

54029**8. OCCUPATION OF DECEASED**

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

Farmer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)Osage Riv. Mo

(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHERNathaniel Rockberry**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Ireland**12. MAIDEN NAME OF MOTHER**Nancy Young**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

New York**14.**INFORMANT _____
(Address)Mrs. Ben V. Rockberry
Permyville Mo**15.**FILED 1-24-28 19 _____Geo. J. Mackay
REGISTRAR**2. MEDICAL CERTIFICATE OF DEATH****16. DATE OF DEATH (MONTH, DAY AND YEAR)**1-2219 28**17.**I HEREBY CERTIFY That I attended deceased from 12-18 1927 to 1-22-28 1928
that I last saw him alive on 1-21-28 1928 and that death occurred, on the date stated above, at 3-16 a m.**THE CAUSE OF DEATH* WAS AS FOLLOWS:**Tuberculosis of Lung
23A
3/11A (duration) 1 yrs. mos. da.**CONTRIBUTORY (SECONDARY)**Influenza (duration) 30 yrs. mos. da.**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, _____

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) G. L. Felt

M. D.

1-24 19 28 (Address) Permyville Mo

*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

Mount Hope Cemetery1-24-1928**20. UNDERTAKER**

ADDRESS

Rollins Young Undr Permyville Mo

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.

