

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

Do not use this space.

3120

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No. **735**

Township.....

Primary Registration District No. **1003**

Registered No. **735**

City.....

No. **Missouri Baptist Midway** St. Ward)

2. FULL NAME

Rosa John

(a) Residence. No. **812 Morgan** St., **25** Ward.

(If nonresident give city 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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Mar 8 1922**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1
				day, hrs. or min.
	5	10	12	

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

10. NAME OF FATHER **Ephraim John**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Brazil South America**

12. MAIDEN NAME OF MOTHER **Lee Georgia**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Brazil South America**

14. INFORMANT (Address) **Ephraim John 812 Morgan**

15. FILED: **20 1078** **Mar 6 Starks**

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 20 19 28**

17. I HEREBY CERTIFY That I attended deceased from **Jan 18** 19**28**, to **Jan 20** 19**28** that I last saw her alive on **Jan 20** 19**28**, and that death occurred, on the date stated above, at **11** a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute broncho pneumonia
Secondary

89B
107A (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) **Mastoiditis** (duration) yrs. mos. da. **2 wks**

18. WHERE WAS DISEASE CONTRACTED **at home**
IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **Jan 18/28**

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **operation**
(Signed) **Philip Frank** M. D.
, 19 (Address) **802 No 3rd**

*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 **Calvary Cemetery** DATE OF BURIAL **Jan 21 1928**

20. UNDERTAKER **Philander Craig Washington**

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 - RECORD

