20 1928

22910-4

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

Do not use this space.

1. PLACE OF DEATH

County Barry County Registration District No. 29 File No. 22910-4

Township Shell Knob Primary Registration District No. 5038 Registered No. 34

City Shell Knob (No. ..... St. ..... Ward)

2. FULL NAME George D Roe

(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: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ HUSBAND OF (OR) ~~WIFE OF~~ Mary E Roe

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1-1845

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
83	6	16	

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) .....
(STATE OR COUNTRY) Tennessee

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) unknown

14. INFORMANT Chas Roe
(Address) Shell Knob Mo

15. FILED Nov 1, 1928 Mrs V.R. Williams Dpt. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 17 1928

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1928, to June 15, 1928, that I last saw him alive on June 15, 1928, and that death occurred, on the date stated above, at 4 p.m.

131 THE CAUSE OF DEATH* WAS AS FOLLOWS: Chronic Nephritis

162

129a

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Old Age

..... (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? Urinalysis

(Signed) Glenn F. Dalyer, M. D

, 19 (Address) Cassville 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: Painter cemetery

DATE OF BURIAL: July 18 1928

20. UNDERTAKER: Horne Funeral Service

ADDRESS: Cassville 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.