

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

Do not use this space.

1749

1. PLACE OF DEATH
County Jackson Registration District No. 899
Township 1st Primary Registration District No. 1002
City St. Mo. (No. General Hosp. #2) St. 24 Ward 2
Registered No. 341

2. FULL NAME Rousseau, Ralph
(a) Residence. No. 1718 Troost St. 24 Ward 2
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 18 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 Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 12 1863
7. AGE: YEARS 65 MONTHS 7 DAYS 2 If LESS than 1 day, ____ hrs. or ____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stove repairer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ohio
(STATE OR COUNTRY)
10. NAME OF FATHER Jas. Rousseau
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tennessee
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Sallie Means
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Georgia
(STATE OR COUNTRY)

14. INFORMANT Mrs. Mary Butler
(Address) 1718 Troost
15. FILED 1-23-29 M. M. Cross REGISTRAR
Asst

2) MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 1929
17. 8th I HEREBY CERTIFY That I attended deceased from Jan 14 1929 to Jan 14 1929
that I last saw him alive on Jan 14 1929, and that death occurred, on the date stated above, at 6:16 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia
107A
1429/0000 (duration) ____ yrs. ____ mos. 6 da.
CONTRIBUTORY Erfacure
(SECONDARY) (duration) ____ yrs. ____ mos. ____ da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? no DATE OF.....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. M. Smith, M. D.
1/15, 1929 (Address) Old City Hosp.

*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 Leads mo DATE OF BURIAL 1-25-29
20. UNDERTAKER H. B. Moore ADDRESS 1820 E 18th

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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