

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

Do not use this space.

13434

1929
COUNTY OF DEATH
County Saline
Township Marshall
City Marshall No. _____

Registration District No. 796
Primary Registration District No. 3038

File No. _____
Registered No. 67
St. _____ Ward _____

2. FULL NAME Grant Gilbert Rozier
(a) Residence No. No State School St. Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 1 mos. 28 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) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-7-1921
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
7 10 24
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo
10. NAME OF FATHER Geo. M. Rozier
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Ruby Rozier
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo

14. INFORMANT Hospital Record
(Address) Marshall Mo
15. FILED 4-6-1929 Mrs. John W. McQuinn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-31 1929
17. I HEREBY CERTIFY, That I attended deceased from March 5, 1928, to 3-31, 1929
that I last saw alive on 3-31, 1928, and that death occurred, on the date stated above, at 3:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchopneumonia
10th
(duration) _____ yrs. _____ mos. 2 ds.
CONTRIBUTORY (SECONDARY) _____
(duration) _____ yrs. _____ mos. _____ ds.

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 Clinical
3 (Signed) J. W. Caples M. D.
31, 1929 (Address) Marshall

*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 St. Louis Mo. DATE OF BURIAL Apr 5, 1929
20. UNDERTAKER J. Swanson ADDRESS Marshall Mo.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Saline Registration District No. 796 File No. _____
 Township _____ Primary Registration District No. 3038 Registered No. 67
 City Marshall (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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)

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 4-6, 1929 Mr. John H. McGuire
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/31 1929

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:

Bacterial pneumonia
did not follow measles
crouping cough
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

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 _____

20. UNDERTAKER _____

ADDRESS _____

FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-13494