

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

Do not use this space.

37767

1. PLACE OF DEATH

County MARION
Township MASON
City HANNIBAL

Registration District No. 547
Primary Registration District No. 3029
No. 1414 LINDELL AVE

File No. _____
Registered No. 298
St. 5 Ward)

2. FULL NAME

CHARLES T. ROUSE
(a) Residence. No. 1414 LINDELL AVE St. 5 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

PAULINE ROUSE

6. DATE OF BIRTH (MONTH, DAY AND YEAR) FEB 19 1907

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
29 9 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. SHOE WORKER
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9. BIRTHPLACE (CITY OR TOWN) HANNIBAL, Mo
(STATE OR COUNTRY)

10. NAME OF FATHER PERRY G. ROUSE

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

12. MAIDEN NAME OF MOTHER Lulu Morgan

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

14. INFORMANT Mrs PAULINE ROUSE
(Address) HANNIBAL, Mo.

15. FILED Dec 29 1929 E. Cousins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-25-1929

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 11:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
suicide by shooting self in left temple

CONTRIBUTORY (SECONDARY) 170 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 170

IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) James O'Donnell BERNARD M.D.
19 (Address) Hannibal 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 Mt Olivet Cemetery DATE OF BURIAL 11-30-1929

20. UNDERTAKER JAMES O'DONNELL ADDRESS HANNIBAL

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

1930
64
8

89

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