

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.

May 23 1930

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

Do not use this space.

12198

1. PLACE OF DEATH

County Franklin
Township Clay
City _____ (No. _____)

Registration District No. 287
Primary Registration District No. 5405

File No. _____
Registered No. 13
St. _____ Ward _____

2. FULL NAME

Rosetta Stafford
(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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>	
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 2, 1899</u>			
7. AGE	YEARS <u>32</u>	MONTHS <u>10</u>	DAYS <u>6</u>
	IF LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer			
9. BIRTHPLACE (CITY OR TOWN) <u>Bernie</u> (STATE OR COUNTRY) <u>Missouri</u>			
PARENTS	10. NAME OF FATHER <u>Harry Medler</u>		
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Mt Carmel</u> (STATE OR COUNTRY) <u>Illinois</u>		
	12. MAIDEN NAME OF MOTHER <u>Shawhan</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Kentucky</u> (STATE OR COUNTRY)			

MEDICAL CERTIFICATE OF DEATH

1. 1
16. DATE OF DEATH (MONTH, DAY AND YEAR) April 8 1930
17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1930 to Apr 8 1930
that I last saw him alive on Apr 7 1930 and that death occurred, on the date stated above, at 6:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Purpura Septicemia
147
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Pericardial valve
sting (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTACTED _____
IF NOT AT PLACE OF DEATH _____
8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) E. J. Cape, M. D.
4-8-30 (Address) Harrisonville

*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 Bernie Mo. DATE OF BURIAL April 8 1930
20. UNDERTAKER W Daniel Horn Co ADDRESS Smith Mo

14. INFORMANT Dolph Stafford
(Address) Harrisonville Mo
15. FILE 4-9-30 E J Cape REGISTRAR

