

MAY 28 1930

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

Do not use this space.

13064
15064

1. PLACE OF DEATH

 County Stoddard
 Township Dix
 City Advance Mo (No. _____)

 Registration District No. 834
 Primary Registration District No. 48-05

 File No. _____
 Registered No. 9
 St. _____ Ward _____

2. FULL NAME

Rose Mary Hart

 (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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 7 - 1930
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
1 16

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) Stoddard Co. Mo
 (STATE OR COUNTRY)
10. NAME OF FATHER Gilbert Hart
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Peru Mo
 (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Helen Sanders
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Illmo Mo
 (STATE OR COUNTRY)

 14. INFORMANT Gilbert Hart
 (Address) Advance Mo

 15. FILED 4-26-1930 J. M. Kearley
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

 16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 23 1930

 17. I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1930, to Apr. 23, 1930, that I last saw h. alive on Apr. 23, 1930, and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pertussis
 18. WHERE WAS DISEASE CONTRACTED 158 (duration) _____ yrs. _____ mos. 10 ds.

CONTRIBUTORY (SECONDARY)

Marasmus (duration) _____ yrs. 1 mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

 19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

 WAS THERE AN AUTOPSY? no

 WHAT TEST CONFIRMED DIAGNOSIS inspection
 (Signed) C. E. Lewis, M. D.

 4-26-1930 (Address) Advance 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 Present Home Cem. DATE OF BURIAL April 24 1930

 20. UNDERTAKER Lloyd D. Morgan ADDRESS Advance 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.

