

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

Do not use this space.
19747

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1006**

City..... (No.....)

File No.

Registered No. **5740**

2. FULL NAME

Arnet Rollins

(a) Residence. No. *4319 St. Louis Ave. #2-10* Ward.....

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>Colored</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Widower</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 4, 1849*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>82</i>		<i>11</i>	<i>13</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Retired Labor*

(b) General nature of industry, business, or establishment in which employed (or employer). *at Home*

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Black Jack, Mo.* (STATE OR COUNTRY) *1*

10. NAME OF FATHER *Jason Rollins*

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

12. MAIDEN NAME OF MOTHER *Caroline Benson*

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

14. INFORMANT *Louis Harris* (Address) *4319 St. Louis Ave.*

15. FILED *9 19 1931* REGISTRAR *C. Young*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 17 1931*

17. I HEREBY CERTIFY, That I attended deceased from *Oct. 21 1930* to *May 17 1931* that I last saw him alive on *May 17 1931* and that death occurred, on the date stated above, at *8:45 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

CONTRIBUTORY (SECONDARY) *Chronic nephritis* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. J. Hebringer*, M. D.

*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 *Washington Park* DATE OF BURIAL *May 21 1931*

20. UNDERTAKER *C. Young* ADDRESS *4400 Kennedy*

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.

