

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

Do not use this space.

File No. **25277**
Registered No. **2718**
St. _____ Ward)

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Law Primary Registration District No. _____
City Kansas City No. Mersey Hospital

2. FULL NAME

(a) Residence. No. Barney Rostine St. Lexington, Mo. 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. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/30/31 19

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

17. I HEREBY CERTIFY, That I attended deceased from 7/30/31 19, to 7/30/31 19, that I last saw him alive on 7/30/31 19, and that death occurred, on the date stated above, at 7:00 P. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 22 1925

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS Days If LESS than 1 day, _____ hrs. or _____ min.
6 2 8

Injection on foot caused by splinter

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

22 (duration) yrs. mos. 14 da.
CONTRIBUTORY (SECONDARY) Tetanus

9. BIRTHPLACE (CITY OR TOWN) Lexington Mo
(STATE OR COUNTRY)

(duration) yrs. mos. 2 da.

10. NAME OF FATHER John Rostine

18. WHERE WAS DISEASE CONTRACTED

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

IF NOT AT PLACE OF DEATH

12. MAIDEN NAME OF MOTHER Minnie Josette

DID AN OPERATION PRECEDE DEATH? DATE OF

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

WAS THERE AN AUTOPSY?

14. INFORMANT Winkler Funeral Home
(Address) Lexington Mo

WHAT TEST CONFIRMED DIAGNOSIS

15. July 30 1931 M. M. Crowe
REGISTRAR

(Signed) W. M. Howard M. D.

7/30/1931 (Address) Mersey Hosp

*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 Lexington Mo. DATE OF BURIAL July 30 1931

20. UNDERTAKER Mrs. C. L. Forster ADDRESS 918 Brooklyn

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

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