

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

Do not use this space.

35365

1. PLACE OF DEATH *Platte*
 County *Platte* Registration District No. *696*
 Township *Fair* Primary Registration District No. *4419*
 City *Tracy, Mo* (No. _____) St. _____ Ward _____

2. FULL NAME *Rosamary Burt*
 (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 *single*
 (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 26 81*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *at home*
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Fair Tracy Mo*
 13. NAME *Wm Burt*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Lexington Ky*
 15. MAIDEN NAME *Ruby gates whitton*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *mo*
 17. INFORMANT *Wm Burt Tracy mo*
 (ADDRESS)
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Pleasant Ridge* DATE *Oct 27 1931*
 19. UNDERTAKER *J. J. Jones*
 (ADDRESS)
 20. FILED *10/26 1931* *J. J. Jones*
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10-26-1931*
 22. I HEREBY CERTIFY, That I attended deceased from *Oct 25 1931* to *Oct 26 1931*
 I last saw her alive on *Oct 25 1931*. Death is said to have occurred on the date stated above, at *3 a. m.*
 The principal cause of death and related causes of importance were as follows:
Bronchial Pneumonia Date of onset *Oct 21 1931*
107A 107A
 Other contributory causes of importance: _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis *chest* as there an autopsy? *no*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? *no*
 If so, specify _____
 (Signed) *E. B. McCalder*, M. D.
 (Address) *Dr. Kell 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.

NOV 25 1931

