

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

Do not use this space.

28686

1. PLACE OF DEATH *Quadian*
 Country *Missouri* Registration District No. *26*
 Township *Salisbury* Primary Registration District No. *3002*
 City *Mexico Mo* (No. _____) St. _____ Ward _____
 2. FULL NAME *Rosa Belle West*
 (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) *married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Rosa West*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown*
 7. AGE *about* YEARS MONTHS DAYS IF LESS than 1 day hrs. of min.
54
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Housewife*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Belleflower Mo.* (STATE OR COUNTRY)
 10. NAME OF FATHER *Sam Rattan*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Indiana* (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER *Rosina Martin*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Priles Co. Mo.* (STATE OR COUNTRY)

14. INFORMANT *Rosa West* (Address) *Belleflower Mo*
 15. FILED *Sept 4 1933* *Era S Milligan* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 4th 1933*
 17. I HEREBY CERTIFY, That I attended deceased from *8-4-33* to *8-4-33*, 19*33* that I last saw her alive on *8-4-33*, 19*33*, and that death occurred, on the date stated above, at *9:30* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Degenerated fibroids of uterus. Uteri hemorrhage.
 (duration) *2* yrs. *4* mos. *4* ds.
 CONTRIBUTORY (SECONDARY) *Hypertension*
 (duration) *5* yrs. *4* mos. *4* ds.

18. WHERE WAS DISEASE CONTRACTED *540*
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *8-31-33*
 WAS THERE AN AUTOPSY? *No*
 WHAT TEST CONFIRMED DIAGNOSIS *Op + Annual*
 (Signed) *J Frank Kelly*, M. D.
 (Address) *Mexico 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 *Belleflower Cemetery* DATE OF BURIAL *9/6th 1933*
 20. UNDERTAKER *R. W. River* ADDRESS *Belleflower 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.

JUL 20 1933

