

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

Do not use this space.

38938

1. PLACE OF DEATH

County Washington
Township Bretton
City (No.) (St.) (Ward ..)

Registration District No. 887
Primary Registration District No. 6179

File No.
Registered No.

2. FULL NAME Rosie Ann Huskey

(a) Residence, No. Ward. Universal Point Ins.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 15-8-1870
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 3 14

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 29 1932
22. I HEREBY CERTIFY, That I attended deceased from Nov 28, 1932, to Nov 29, 1932.
I last saw her alive on Nov 29, 1932. Death is said to have occurred on the date stated above, at 5:30 a.m.
The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
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) Nov 1932
11. Total time (years) spent in this occupation 14

Diphtheria
(13) 137
Date of onset about 1930
Other contributory causes of importance: Anasarcia

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cadbury Kentucky
13. NAME Wm Hall
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
15. MAIDEN NAME Kathleen Chankalaie
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

Name of operation Date of
What test confirmed diagnosis diphtheria Was there an autopsy? no

17. INFORMANT (ADDRESS) Husband
18. BURIAL, CREMATION, OR REMOVAL

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

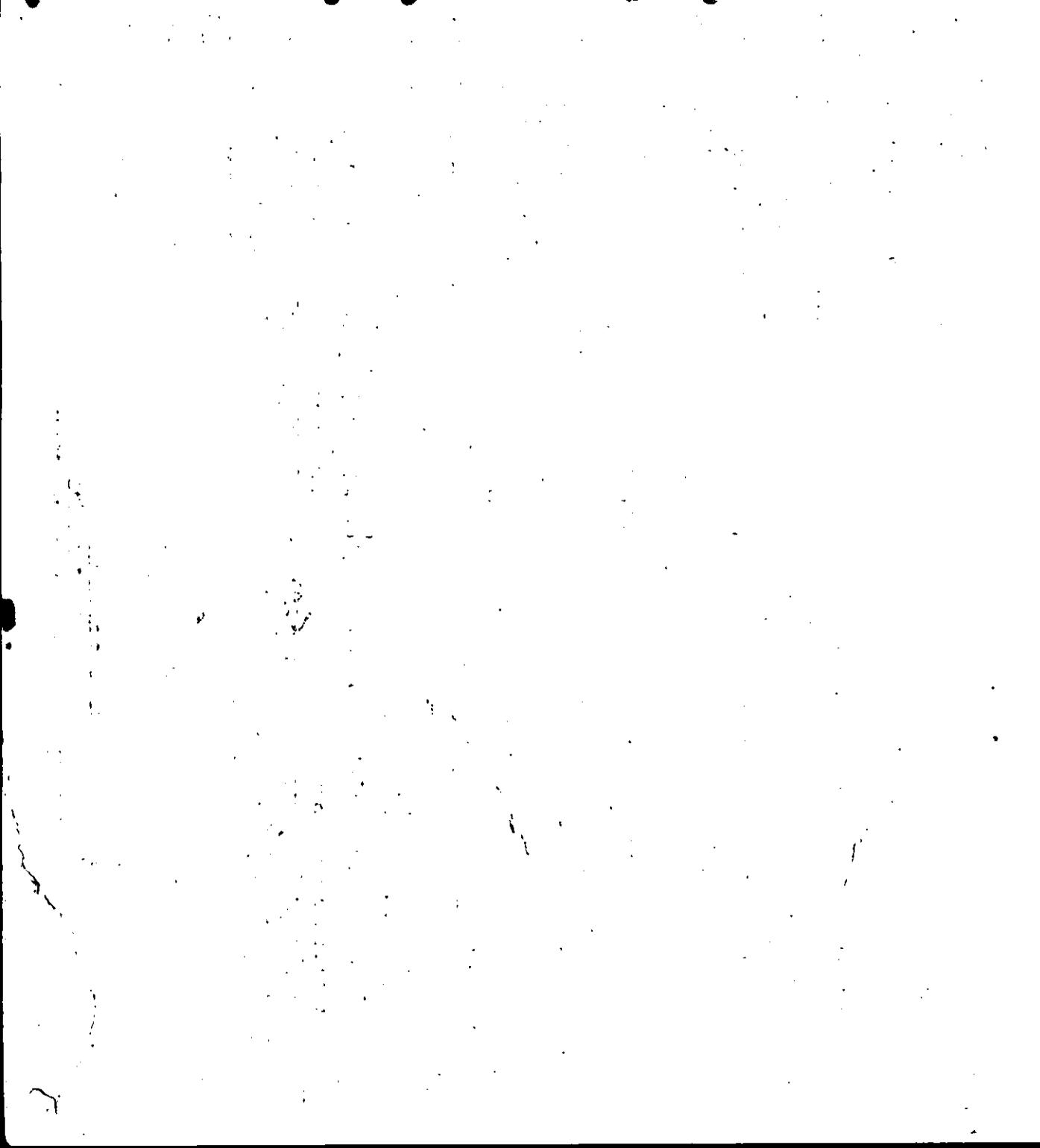
19. UNDERTAKER (ADDRESS) Sparks & Sparks
20. FILED Nov 6 1933 G. F. Pressnell Registrar.

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) T. H. Dempsey, M. D.
(Address) Potosi 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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Washington Registration District No. 887
Township Gretna Primary Registration District No. 6179
City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*writes the word*) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

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. _____

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) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE Till DATE Nov 29 1938

19. UNDERTAKER Spalds + Spalds (ADDRESS) _____

20. FILED Nov 7 1938 G.F. Crosswell Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 29 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

_____ Date of onset _____
_____ other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____
If so, specify _____

(Signed) _____, M. D.
(Address) _____

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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