

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.

APR 25 1934

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

Do not use this space.

11708

53

1. PLACE OF DEATH

County Winn
Township Washington
City Nevada (No.)

Registration District No. 875
Primary Registration District No. 616a

File No.
Registered No.
St. Ward)

2. FULL NAME

(a) Residence, No. Elizabeth Ann Rose
(Usual place of abode) Washington Township Ward.

(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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 4 - 1933</u>		
7. AGE	YEARS	MONTHS
	<u>1</u>	<u>1</u>
		<u>11</u>
	If LESS than 1 day, hrs. or min.	

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	<u>—</u>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	<u>—</u>
	10. Date deceased last worked at this occupation (month and year)	<u>—</u>
	11. Total time (years) spent in this occupation	<u>—</u>

12. BIRTHPLACE (CITY OR TOWN) Nevada
(STATE OR COUNTRY) no

13. NAME William T Rose

14. BIRTHPLACE (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Lincoln Co Mo

15. MAIDEN NAME Edna Wierford

16. BIRTHPLACE (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Mo

17. INFORMANT Mrs Edna Rose
(ADDRESS) Nevada Mo

18. BURIAL, CREMATION OR REMOVAL Hamloch Cemeter DATE 3-18 1934

19. UNDERTAKER Ferry Funeral Home
(ADDRESS) Nevada Mo

20. FILED 3/17 1934 W. M. Hume
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 16 1934

22. I HEREBY CERTIFY That I attended deceased from Mar 14 1934, to Mar 16 1934.

I last saw him alive on Mar 13 1934. Death is said

to have occurred on the date stated above, at 6:30 m.

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

Bronchial Pneumonia Date of onset

Other contributory causes of importance

1079

1079

Name of operation..... Date of.....

What test confirmed diagnosis? Sputa 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.....

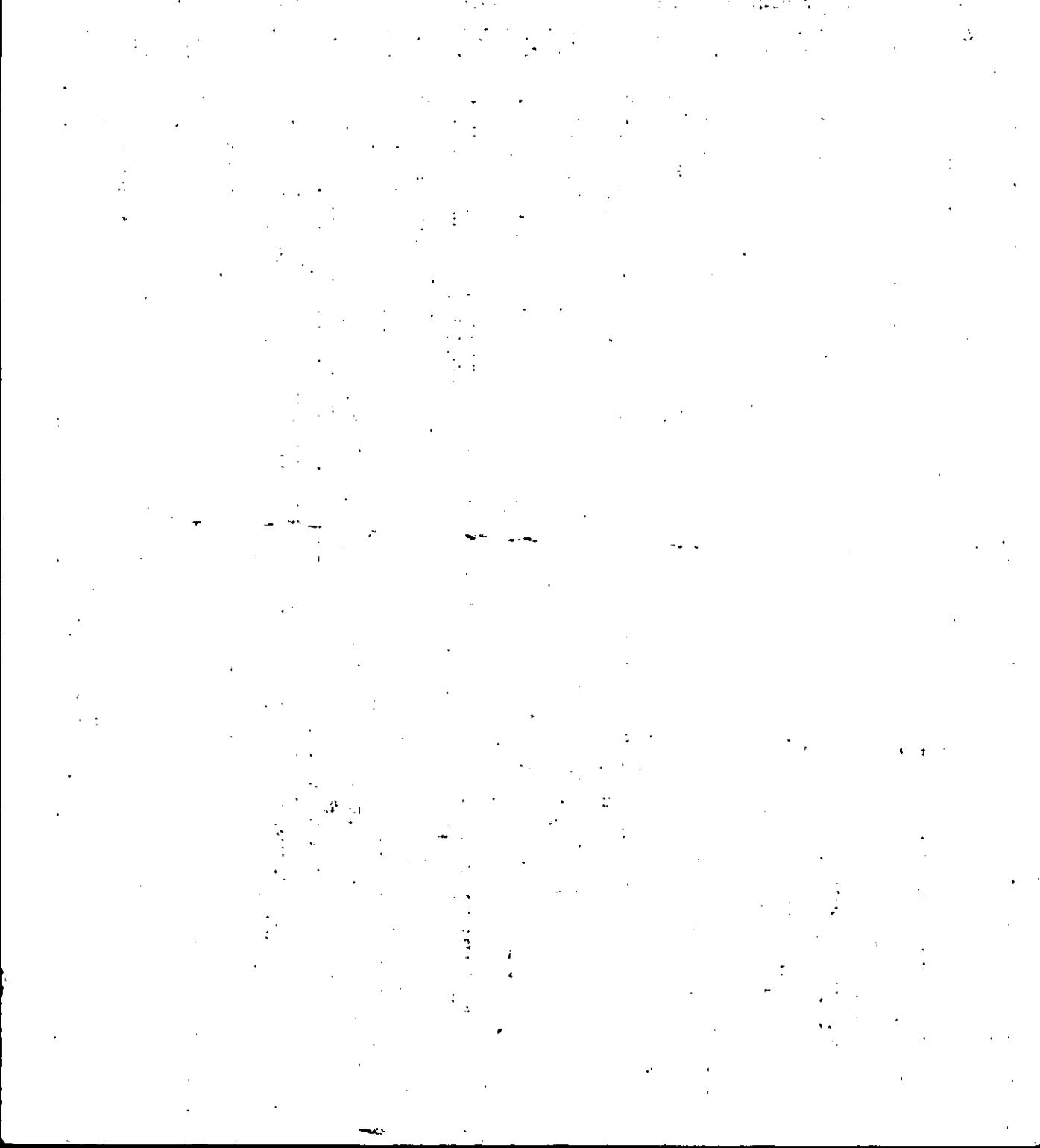
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) J. M. Hater, M. D.

(Address) Nevada Mo



Vernon

WASHINGTON

53

11708

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Elizabeth Ann Rose
Who died at _____ on Mar 16 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex F Color or race W Single, married, widowed or divorced: ✓

Date of birth Feb 4 - 1939 Age: Years 1 Months 1 Days 11

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer; bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Bronchial pneumonia

Other contributory causes of importance none 1070

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician J. M. Yates

Address of physician Nevada mo

Signature of Registrar M. Eichinger Date filed Oct. 31 - 1934

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh

Special Agent.

Reg. Dist. No. 872
Primary Reg. Dist. No. 6162

UNITED STATES GOVERNMENT

OFFICE OF THE SECRETARY OF DEFENSE
ATTENTION: ASSISTANT SECRETARY FOR PERSONNEL

MEMORANDUM FOR THE SECRETARY OF DEFENSE
SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

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