LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

JUN 20

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

Do not use this space.

16210

1. PLACE OF DEATH
County Dade
Township Polk
City ..... (No. ..... St. ..... Ward)

Registration District No. 235
Primary Registration District No. 5322

File No. .....
Registered No. 14

2. FULL NAME Rosa E Dover

(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 Francis E Dover

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 23-1861

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
72	7	26	

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) .....

11. Total time (years) spent in this occupation .....

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

13. NAME Will Borland

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know

15. MAIDEN NAME Devorah Sexton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know

INFORMANT (ADDRESS) Francis E Dover Everton Mo

BURIAL, CREMATION, OR REMOVAL Crabtree

PLACE Sterling Nebras DATE May 23 1934

UNDERTAKER (ADDRESS) Will Mack Dadeville Mo

FILED May 21 1934 Morris Miller Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May-19 - 1934

22. I HEREBY CERTIFY, That I ~~attended~~ wrote deceased ~~from~~ May 20, 1934 to ....., 19....

I last saw her alive on ....., 19.... Death is said to have occurred on the date stated above, at 9:20 P.M.

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

Date of onset

Cerebral Hemorrhage -
Right Hemophlegia

Other contributory causes of importance:

82

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) T J Driedel, M. D.

(Address) Greenfield Mo.

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CERTIFICATE OF DEATH

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File No.....

Registered No.....

1. PLACE OF DEATH

County..... Registration District No.....

Township..... Primary Registration District No.....

City..... (No..... , ... St. ..... Ward)

2. FULL NAME.....

(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 | 4. COLOR OR RACE | 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)

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..... DATE.....19....

19. UNDERTAKER.....
(ADDRESS)

20. FILED..... 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 19....

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., 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 ons

.....

.....

.....

.....

.....

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 follow.

Accident, suicide, or homicide?..... Date of injury.....

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).....

(Address).....