

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

Do not use this space.

12409

1. PLACE OF DEATH

33 County DeWitt  
Township Current  
City Montauk

Registration District No. 1035  
Primary Registration District No. 5371

File No. \_\_\_\_\_  
Registered No. 12 St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. Edwin C. Mac Rossin Ward. \_\_\_\_\_  
(Usual place of abode) Montauk Mo. 3.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Oct 12</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>1887</u>		
7. AGE	YEARS <u>48</u>	MONTHS <u>5</u>
	DAYS <u>22</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>Laboren</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>CCC Parkwork</u>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation <u>2</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Philadelphia Pa</u>		
FATHER	13. NAME <u>Don't know</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't know</u>	
	15. MAIDEN NAME <u>Don't know</u>	
MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't know</u>	
	17. INFORMANT (ADDRESS) <u>Jennie Lillian</u>	
18. BURIAL, CREMATION, OR REASON PLACE <u>Louisa Cemetery</u> DATE <u>5/7</u>		
19. UNDERTAKER (ADDRESS) <u>H. D. Holman</u>		
20. FILED <u>4/29</u> 19 <u>35</u> <u>J. A. Kresock</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 4, 1935

22. I HEREBY CERTIFY, That I attended deceased from November 1934 to April 4, 1935  
I last saw him alive on April 3, 1935. Death is said to have occurred on the date stated above, at 4:00 A.M.  
The principal cause of death and related causes of importance were as follows:  
Heart failure - Probably acute dilatation Date of onset \_\_\_\_\_

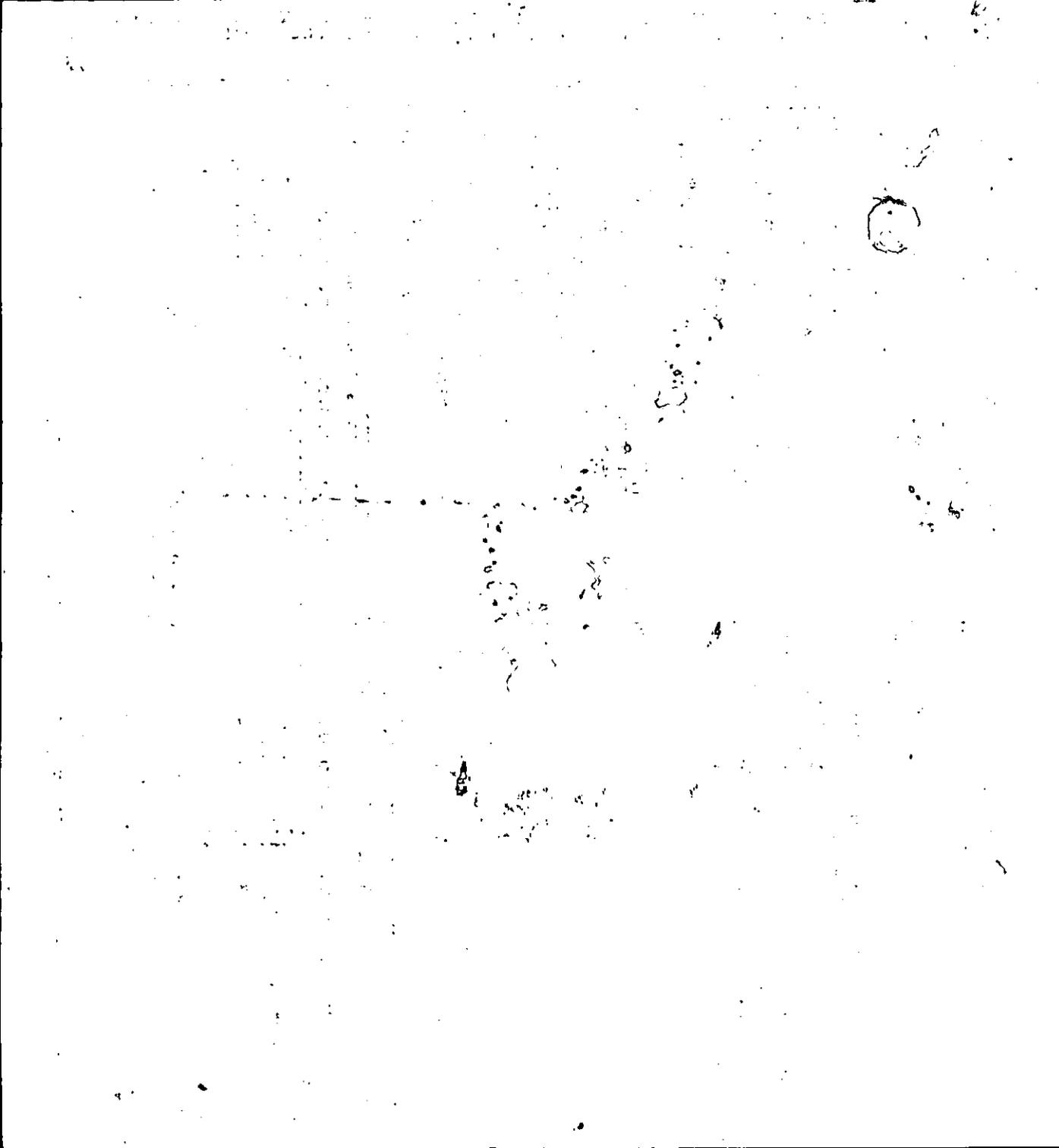
Other contributory causes of importance:  
90

Name of operation None Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? None Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? None  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
CCC Co 1770, in Barracks  
Manner of injury None  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) Austin P. Haller, M. D.  
(Address) Montauk 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.



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

ALL INFORMATION CALLED  
FOR MUST NOT BE USED FOR  
THIS SUPPLEMENTARY.

12409

**1. PLACE OF DEATH**

County St. Louis  
Township Current  
City St. Louis (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 1035  
Primary Registration District No. 5371

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME** Edwin C. Mac Rossin

(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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 4 1935

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 48 5 22

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. \_\_\_\_\_  
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 \_\_\_\_\_

Heart failure probably dilatation myocarditis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Other contributory causes of importance: 9281

13. NAME \_\_\_\_\_

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

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

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. \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) Austin J. Haller, M. D.  
(Address) Montreal

20. FILED 4/29 1935 J. A. Kusack Registrar

**SUPPLEMENTARY**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

5-12409