

AUG 18 1936 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

25915

1. PLACE OF DEATH

County Clark
Township Clay
City Clay (No)

Registration District No. 189
Primary Registration District No. 5248

File No.
Registered No.
St. Ward)

2. FULL NAME

Robert Joseph Rossi

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, ~~Widowed or Divorced~~ HUSBAND OF Rosanna Jane Harrison (or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 6, 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.
87 | 6 | 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) New York City
(STATE OR COUNTRY) New York

10. NAME OF FATHER Joseph Rossi

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

14. INFORMANT Mr. Mel Rossi
(Address) Alexandria, Mo.

15. FILED Aug. 19, 1936 Dr. F. A. S. Rebo
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 15, 1936

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1936, to July 15, 1936 that I last saw him alive on July 15, 1936, and that death occurred, on the date stated above, at 1:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac insufficiency
valvular chronic
(duration) 10 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Tissue Hypoxia
(duration) 20 ds.

18. WHERE WAS DISEASE CONTRACTED AT
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? AT

(Signed) A. Johnson, M. D.

, 19 (Address) Wayland 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 Sand Cemetery DATE OF BURIAL 7/18 1936

20. UNDERTAKER H. F. Kircher ADDRESS Wayland

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

