

FEB 25 1937

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

Do not use this space.

1627

1. PLACE OF DEATH

County Jackson  
Township 10  
City R. O. No.

Registration District No. 399  
Primary Registration District No. 9  
(No. 919 West 17th Street)

File No. 448  
Registered No. 448  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. 1662 Madison 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 <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>May La Rose</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct-9-1887</u>		
7. AGE	YEARS <u>49</u>	MONTHS <u>7</u>
	DAYS <u>13</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>laborer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>Wab. R. Co.</u>	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation <u>31</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>no</u>		
MOTHER	13. NAME <u>Levi La Rose</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>no record</u>	
	15. MAIDEN NAME <u>no record</u>	
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>no record</u>	
	17. INFORMANT <u>Mrs. Mae La Rose</u> (ADDRESS) <u>1662 Madison, Ave.</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Genevieve, Mo.</u> DATE <u>Jan-23-37</u>		
19. UNDERTAKER (ADDRESS) <u>Mrs. E. L. Forster</u> <u>918 Broadway</u>		
20. FILED <u>Jan 24 1937</u> <u>M. M. Conover</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan-22-37

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

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 7:15 pm.

The principal cause of death and related causes of importance were as follows:  
Chronic fibros myocarditis  
Date of onset \_\_\_\_\_

Other contributory causes of importance:  
W. A. W.

Name of operation \_\_\_\_\_ Date \_\_\_\_\_  
What test confirmed diagnosis? Autopsy 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 connected to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) [Signature], M. D.  
(Address) [Signature]

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

