

SEP 17 1937

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

Do not use this space.

30642

1. PLACE OF DEATH

County Century Registration District No. 309 File No. _____
Township _____ Primary Registration District No. 4155 Registered No. 41
City Albany Rose Hospital Albany St. _____ Ward _____

2. FULL NAME

Frank Dawson Rose
(a) Residence, No. One Fall Mt. P. O. 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

MEDICAL CERTIFICATE OF DEATH

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>Beulah Cooper</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>December 21-1907</u>		
7. AGE	YEARS <u>29</u>	MONTHS <u>8</u>
	DAYS <u>16</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>farmer</u>	
	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 COUNTY) <u>Century Mo</u>		
FATHER	13. NAME <u>Joseph Rose</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Century Mo</u>	
MOTHER	15. MAIDEN NAME <u>Lilla Pearson</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
17. INFORMANT <u>Mrs Frank Rose</u> (ADDRESS) <u>Albany Mo P. O.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Chandlers</u> DATE <u>Aug 8 1937</u>		
19. UNDERTAKER <u>Wicks Funeral Home</u> (ADDRESS) <u>Albany Mo</u>		
20. FILED <u>Recd. 7, 1937</u> <u>W. H. Martin</u> Registrar.		

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 6 1937

22. I HEREBY CERTIFY, That I attended deceased from Aug 2, 1937, to Aug 6, 1937

I last saw him live on Aug 6, 1937. Death is said to have occurred on the date stated above, at 12:45 P.M.

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

Acute Pancreatitis Date of onset 8-3-37

Other contributory causes of importance:

Acute Intestinal Obstr. 8-3-37

Name of operation Explor Date of 8-5-37What test confirmed diagnosis? op Was there an autopsy? no

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? no

If so, specify _____

(Signed) Frank H. Rose, M. D.(Address) Albany, Mo.

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

2/10/10

NO. 10

10

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
- (a) County Gentry Registration District No. 309
- (b) Township Albany Primary Registration District No. 4185
- (c) City Albany (d) Street No. _____ St. _____
- (e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (f) How long in U.S., if of foreign birth? _____ yrs. mos. ds.
2. PRINT FULL NAME Frank Davidson Rose
- (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE YEARS <u>29</u>	MONTHS <u>8</u>	DAYS <u>16</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		If LESS than 1 day, _____ hrs. or _____ min.
9. Industry or business in which work was done, as saw mill, bank, etc.		11. Total time (years) spent in this occupation
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
13. NAME		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
15. MAIDEN NAME		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19__		
19. FUNERAL DIRECTOR (ADDRESS)		
20. FILED <u>Oct 28 1937</u> <u>W. H. Martin</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 6 1937

22. I HEREBY CERTIFY, That I attended deceased from _____, 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:

Chronic adhesions
Result of Peritonitis 15 yrs
before
acute intestinal ob-
struction

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 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) Frank H. Rose, M. D.
(Address) Albany ma

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state CAREFULLY. OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAREFULLY. OCCUPATION should be stated EXACTLY.

SUPPLEMENTARY

S-30642