

DEED MAY 1 0 1939

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

16218
Do not use this space.

1. PLACE OF DEATH

(a) County Saint Louis Registration District No. 784
(b) Township Charadelat Primary Registration District No. 200 Registered No. 831
(c) City Jefferson Barracks (d) Street No. Unkn. (If death occurred in Hospital or Institution, write its name instead of street and number) St. Vet Hosp.
(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 Edward ROSE

(a) Residence, No. R. R. #4-a St. Mount Vernon, Illinois.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 (OR) WIFE OF Mrs. Opel Rose

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 2, 1893

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
45 4 14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as 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) Harrisburg, Illinois

13. NAME The Rose

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

15. MAIDEN NAME Mollie Butler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT (ADDRESS) Clinical Registrar, Jefferson Barracks, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Oakwood DATE May 8 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. B. Myers Mt Vernon, Ill.

20. FILED MAY - 6 1939 W. B. Myers M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6 1939

22. I HEREBY CERTIFY, That I attended deceased from March 26 1939, to May 6 1939

I last saw him alive on May 6 1939. Death is said to have occurred on the date stated above, at 3:37A m.
The principal cause of death and related causes of importance were as follows:

Carcinoma, left face with metastasis to cervical region. Date of onset 8/15/38

Other contributory causes of importance: Hemorrhages, numerous 3-30-39

Name of operation None Date of -
What test confirmed diagnosis? clinical manif. and lab. 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?
If so, specify -
(Signed) C. W. HUGHES, Chief Med. Officer, M. D.

(Address) VAE

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.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con
with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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16216-
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
 (b) Township..... Primary Registration District No. 200 Registered No. 831
 (c) City..... (d) Street No. Pets. Hosp. St. Mo.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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

(a) Residence, No. R.R. # 4 St. Mo. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6 1919

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

22. I HEREBY CERTIFY, That I attended deceased from

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

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:

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
45 4 14

Cardioma face - metastasis cervical region

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

hemorrhages - numerous

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

Other contributory causes of importance:

FATHER 13. NAME

Name of operation..... Date of.....

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis?..... Was there an autopsy? No

MOTHER 15. MAIDEN NAME

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.

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Manner of injury.....
 Nature of injury.....

17. INFORMANT (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

(Signed) C. M. Hughes, M. D.
 (Address) V. A. F.

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED....., 19..... Local Registrar.

SUPPLEMENTARY

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.

