

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.

REC'D AUG 7 1939

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

Do not use this space.

27020

1. PLACE OF DEATH

County Stoddard Registration District No. 836  
Township Elk Primary Registration District No. 6100  
City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 27

2. FULL NAME

1015 Franklin Delano Roosevelt  
(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

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 11 - 1938

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
1 4 27 5

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Infant

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 COUNTRY) Stoddard Co. Mo.

13. NAME William L. Roosevelt

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clay Co. Mo.

15. MAIDEN NAME Rosie Lee Wood

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wright County Mo.

17. INFORMANT (ADDRESS) William L. Roosevelt

18. BURIAL, CREMATION, OR REMOVAL PLACE Taylor Cem DATE June 8 1939

19. UNDERTAKER (ADDRESS) Watkins Undertakers Parma Mo.

20. FILED 7-31 1939 Laura Hopkins Registrar

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from June 4, 1939, to June 6, 1939

I last saw him alive on June 6 8:30 P.M., 1939. Death is said to have occurred on the date stated above, at 12 P.M.

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

Acute Colitis Date of onset \_\_\_\_\_

Other contributory causes of importance: None

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? clinical 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) Dr. Edward Ford, M. D.

(Address) Parma Mo.

RECEIVED

District Health Officer No. 2,

District File Number 839-111

Date Filed 8-4