

N. B.—Every item of information should be carefully supplied. No entry should be made unless the cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

29910  
Do not use this space.

REC'D SEP 21 1939

1. PLACE OF DEATH  
 (a) County Pettis Registration District No. 668  
 (b) Township..... Primary Registration District No. 3032  
 (c) City Sedalia (d) Street No. ....  
 (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 300 Earnest Samuel Roode  
 (a) Residence, No. 323 N. Grand St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

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. Martha Roode

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 11, 1861

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, .....hrs. or .....min.
	<u>78</u>	<u>6</u>	<u>9</u>	

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.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 20 1939

22. I HEREBY CERTIFY, That I attended deceased from 36 to Aug 20, 1939  
 I last saw him alive on Aug 20, 1939. Death is said to have occurred on the date stated above, at 11:15 am.  
 The principal cause of death and related causes of importance were as follows:  
Myocarditis  
Chronic  
 Date of onset 1936

Other contributory causes of importance: A.C.

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? no  
 If so, specify A. L. Walter, M. D.  
 (Signed) Sedalia (Address) no

12. BIRTHPLACE (CITY OR TOWN) Elk Horn Co.  
 (STATE OR COUNTRY) Wisconsin

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) U. S. A.  
 (STATE OR COUNTRY)

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) U. S. A.  
 (STATE OR COUNTRY)

17. INFORMANT Harold E. Roode  
 (ADDRESS) Sedalia

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Carmel Baptist DATE Aug 22 1939

19. FUNERAL DIRECTOR (NAME) Duane Ewing  
 (ADDRESS) Sedalia

20. FILED Aug 21, 1939 Mrs Harry Sneed  
 (Address) Sedalia  
 Official Registrar.

Dr. Walters

RECEIVED  
District Health Officer No. 8,  
Office File Number  
9/7/39

**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, Aug 20

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed

*Phane Ewing*

Licensed Embalmer No. 38747

P. O. Address

*Sedalia Mo*

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

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