

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Registration District No. 134

Primary Registration District No. 5189

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Combs Twp.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community 10 days  
years, months or days

3. (a) PRINT FULL NAME Perry B. Rose, Jr.

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Bert Howard

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov 3, 1879  
(Month) (Day) (Year)

8. AGE: Years 60 Months 1 Days 19 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation Stationary Engineer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Asron F. B. Rose

13. Birthplace Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Goller

15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wm Rose

(b) Address Wakenda, Mo., R. F. D.

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill

18. (a) Signature of funeral director Starving Funeral Home  
(b) Address Carrollton Mo.

19. (a) Dec. 31 (b) Mrs. A. G. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Wis. (b) County \_\_\_\_\_

(c) City or town Menomonone  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24 year 1939 hour 2 minutes 20 P. M.

21. I hereby certify that I attended the deceased from December 24th, 1939, to December 24, 1939;  
that I last saw him alive on 12:45 pm Dec. 24, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death <u>Pulmonary Edema</u>	Duration <u>12h.</u>
Due to <u>acute myocarditis</u>	
Due to <u>Pneumonia</u>	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations _____	PHYSICIAN  Underline the cause to which death should be charged statistically.
Of autopsy _____	

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work (e) Means of injury \_\_\_\_\_

23. Signature Wm H. Plat, M.D. (M. D. or other) \_\_\_\_\_  
Address Carrollton, Missouri Date signed 12/27/39

RECEIVED  
District Health Officer No. 8,  
District File Number  
1/5/40

**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..... *Ben W Gibson*

Licensed Embalmer No. *2961*

P. O. Address *Carrollton Ind*

**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.**