DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 18 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6236

Registration District No. 144

Primary Registration District No. 5207 V

Registrar's No.

1. PLACE OF DEATH:

(a) County Carter

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

(c) Name of hospital or institution: 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

In this community Ten Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carter

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

(d) Street No. 0 Near Ellsinore Mo. (If rural, give location)

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

3. (a) PRINT FULL NAME Gustavus Adolphus Rose

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 Mabel Ried Rose

6. (c) Age of husband or wife if alive D.K. years

7. Birth date of deceased Sept (Month) 15 (Day) 1864 (Year)

8. AGE: Years 75 Months 2 Days 29 If less than one day ..... hr. ..... min.

9. Birthplace LaPorte Ind. (City, town, or county) / (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name Reginald Heber Rose

13. Birthplace Lynchburg Va. (City, town, or county) / (State or foreign country)

14. Maiden name Dosnea Farley

15. Birthplace LaPorte Ind. (City, town, or county) / (State or foreign country)

16. (a) Informant's own signature

(b) Address

17. (a) Carthage Mo. (Burial, cremation, or removal) (b) Date thereof Jan. 35-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Carthage Mo.

18. (a) Signature of funeral director Guy-Leuchel

(b) Address Von Missouri

19. (a) Mar 8-1940 (Date received local registrar) (b) Pearl Brooks (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 14 year 1940 hour Dont Know minute ..... M.

21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...; that I last saw h... alive on ....., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Endocarditis	yrs.
Due to Arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death) G. U.	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Guy Leuchel Coroner (M. D. or other)

Address Von Mo. Date signed 12-21-39

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 5-17-39 I X19511

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.....,

and under my personal supervision.

RECEIVED
District Health Officer No. 8,
District File Number 340296
Date Filed 3/12/40

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.