

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.

FEB 17 1941

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

3047
Do not use this space.

1. PLACE OF DEATH

(a) County Jefferson Registration District No. 421
 (b) Township Festus, Mo. Primary Registration District No. 4249 Registered No. 9
 (c) City Festus, Mo. (d) Street No. 1 St.
 (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. MARY ROTH Festus, Mo. St. 0 (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 8 - 1854

7. AGE YEARS 86 MONTHS 11 DAYS 18 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework
 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) St. Genevieve Co. Mo.

FATHER 13. NAME John Kennen

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

MOTHER 15. MAIDEN NAME Matilda Brown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Genevieve Co. Mo.

17. INFORMANT (ADDRESS) Sarah Rudolph
Festus, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Roth Cemetery DATE 1-28-1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FINK JANDA, Co
FESTUS, Mo.

20. FILED 2-3 19 41 E. Rutledge Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-26-1941

22. I HEREBY CERTIFY, That I attended deceased from January 24, 1941 to January 26, 1941
 I last saw her alive on January 25, 1941. Death is said to have occurred on the date stated above, at 10 A. m.

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

Cerebral Apoplexy Date of onset Jan 24, 41

Other contributory causes of importance: g2h

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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) Clarence E. Crosby, D.O. M.D.
 (Address) 204 Main St., Festus, Mo.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
BUREAU OF HEALTH CARE LICENSING
LICENSING DIVISION

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 comply with the above constitutes grounds for revocation of license.)

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