

FILED JUL 19 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

22478

State File No. \_\_\_\_\_

Registration District No. 718

Primary Registration District No. 5949

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Putnam

(b) City or town Jackson Mo

(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Kittie May Roof

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

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

4. Sex Female 5. Color or race W

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife D C Roof 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased (Month) 5 (Day) 12 (Year) 1869

8. AGE: Years 72 Months 1 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Iowa (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation house wife

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

12. Name A B Averill

13. Birthplace New York (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name Frank Rice

15. Birthplace unknown (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant D B Roof

(b) Address Lemora Mo

17. (a) Burial (b) Date thereof June (Month) (Day) (Year) \_\_\_\_\_

(c) Place: burial or cremation Lemora Mo

18. (a) Signature of funeral director J. C. [unclear]

(b) Address McDonville, Mo

19. (a) June 22-41 (b) New [unclear] (State received local registrar) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Putnam

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

(d) Street No. Lemora, Mo R 70 (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 19 year 1941 hour 1:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from March \_\_\_\_\_, 1941, to June 13 \_\_\_\_\_, 1941, that I last saw her alive on June 13 \_\_\_\_\_, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death complete heart block Duration 7

Due to partial block 3 years

Due to Hypertension 10 years

Other conditions Cholecystitis 2

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? 645 (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature L. H. [unclear] (M. D. or other) \_\_\_\_\_

Address Gallock Date signed June 20

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 7-41-1296

Date Filed JUL 16 1941

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:

*Marl E. Husted*

Licensed Embalmer No. 3394

P. O. Address..... *Amherst*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 22478  
Registrar's No. \_\_\_\_\_

Registration District No. 718

Primary Registration District No. 5949

1. PLACE OF DEATH:

Putnam

- (a) County.....
- (b) City or town.....  
(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 years, months or days)

3. (a) PRINT FULL NAME Kittie May Roof

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex W 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased May 12 1869  
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof June 20 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. June 20 1946 (a) (Date received local registrar) N. W. Gallatin (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State..... (b) County.....
- (c) City or town.....  
(If outside city or town limits, write "RURAL")
- (d) Street No.....  
(If rural, give location)
- (e) Citizen of foreign country..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH Month June day 19  
year 1946 hour..... 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.

Immediate cause of death.....  
Due to.....  
Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....

Duration

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?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-22478