S. No. 2
M—2-43
. 5-17-39
-I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

27427

State File No. .....

FILED SEP 13 1945

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 647

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: (1000 block S. Fort) Route #8
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None / (Specify whether
In this community 72 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 37

(c) City or town Springfield, 2
(If outside city or town limits, write "RURAL")

(d) Street No. 733 S. Fort 6
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) /

If yes, name country .....

3. (a) PRINT FULL NAME Joe Rose

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Mollie Pfaff Rose

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

7. Birth date of deceased May (Month) 22, (Day) 1873 (Year)

8. AGE: Years 72 Months 2 Days 25 If less than one day ..... hr. ..... min.

9. Birthplace Greene County, (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business On Farm

FATHER
12. Name G. B. Rose
13. Birthplace Greene County, (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Elizabeth Utt
15. Birthplace St. Charles, (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Miss Jessie Rose
(b) Address Springfield, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof August 20, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Brookline Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri

19. (a) 8-20-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17th, year 1945 hour 9:30 minute A. M.

21. I hereby certify that I attended the deceased from Aug. 15, 1945, to Aug. 17, 1945 that I last saw him alive on Aug. 16, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

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

23. Signature W. W. Dobbs (M. D. or other)
Address Springfield, Mo. Date signed Aug 17/45

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(Licensed Embalmer's Statement on Reverse Side)

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. 2044

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, fact should be so stated above.