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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 15 1945

State File No. 30929

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 121

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 303 Mansur Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 80 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Livingston 59
(c) City or town Chillicothe 1
(If outside city or town limits, write "RURAL")
(d) Street No. 303 Mansur Street 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Alice Roe

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife David Roe

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

7. Birth date of deceased August (Month) 26th. (Day) 1865 (Year)

8. AGE: Years 80 Months 0 Days 12 If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Jack Baker
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs Bert Butler
(b) Address Chillicothe, Missouri.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 11- '45 (Month) (Day) (Year)
(c) Place: burial or cremation Breckinridge, Mo.

18. (a) Signature of funeral director Norman Funeral Home
(b) Address Chillicothe, Missouri.

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8th.
year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from Sept 6, 1945 to Sept 8, 1945
that I last saw her alive on Sept 8, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	1 Week
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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 M E Everett DO (M. D. or other)
Address Chillicothe Mo Date signed 9-10-45

1514

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11,
District File Number
Date Filed

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

Frank L. Smiley, Registered Apprentice No.

working under my personal supervision.

Signed Frank L. Smiley

Licensed Embalmer No. 770

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—3-45
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 121

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe
(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 80 years.
years, months or days)

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

3. (a) PRINT FULL NAME Alice Roe

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 26 (Day) 1865 (Year)

8. AGE: Years 80 Months 0 Days 12 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

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

19. (a) Sept 10, 1945 (Date received local registrar) Frances B. Neill (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept day 8
year 1945 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
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 (M. D. or other)

Address Date signed

30929