DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41061

FILED JAN 14 1946

Registration District No. 14 Primary Registration District No. 5377 Registrar's No. 14

1. PLACE OF DEATH:
(a) County DeKalb (Grant Twp.)
(b) City or town Maysville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: home
(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) 80 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County DeKalb 32
(c) City or town Maysville Rural (If outside city or town limits, write "RURAL") 0 0
(d) Street No. (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME REZIN PERRY ROSE
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced widower
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 6 (Day) 1855 (Year)

8. AGE: Years 90 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business

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

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

16. (a) Informant Byron Rose
(b) Address maysville mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-45 (Month) (Day) (Year)
(c) Place: burial or cremation Amity Mo
18. (a) Signature of funeral director John D Bruce
(b) Address Maysville Mo
19. (a) 12-4-45 (Date received local registrar) (b) Roscoe Davidson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 29 year 1945 hour 11 minute 2 A.M.
21. I hereby certify that I attended the deceased from Nov 28, 1945 to Nov 29, 1945 that I last saw him alive on Nov 29, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Senility	
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 Dr. Lonnie Fowler (M. D. or other) M.D.
Address Maysville Mo Date signed 11-30-45

1557 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE INK

DISTRICT HEALTH OFFI
Cameron, Mo.

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 John G Brown

Licensed Embalmer No. 3933

P. O. Address Maysville Mo

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.

2B
-45
43880

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. 99 Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County McKalb

(b) City or town Maysville - Grant Twp
(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)

In this community .....

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 Regni P. 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 Wid

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

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

7. Birth date of deceased Feb 6 1849
(Month) (Day) (Year)

8. AGE: Years 90 Months 9 Days 13 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 .....

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

MEDICAL CERTIFICATION

SUPPLEMENTARY 29

20. DATE OF DEATH: Month ..... Day ..... year 1941 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 .....

41061