

FILED JUN 12 1946  
Registration District No. 209

Primary Registration District No. 3043

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

1. PLACE OF DEATH:  
(a) County Marion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Leaning Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Entire life (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Calvert Rosser  
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 single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased February 26 1929  
(Month) (Day) (Year)

8. AGE: Years 17 Months 2 Days 20 If less than one day  
\_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation high school student

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name John Roy Rosser  
13. Birthplace Monroe City Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Glacie Calvert  
15. Birthplace Warrenton Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. John Rosser  
(b) Address 1011 Hope, Hannibal, Mo.  
17. (a) Burial (b) Date thereof May 18, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Grand View Burial Park

18. (a) Signature of funeral director Ray P. Schwartz  
(b) Address 1022 Broadway, Hannibal, Mo.  
19. (a) 5-22-46 (b) Dr. E. M. Lucke  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Marion <sup>64</sup>  
(c) City or town Hannibal <sup>3</sup>  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2201 Hope St. <sup>4</sup>  
(If rural, give location) <sup>0</sup>  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16  
year 1946 hour 2 minute 46 A.M.  
21. I hereby certify that I attended the deceased from May 9  
19 46 to May 16 19 46  
that I last saw him alive on May 16 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis Duration 14 da  
Due to Staphylococcus 14 da  
Due to \_\_\_\_\_

Other conditions Chronic Bilateral Otitis Media  
(Include pregnancy within 3 months of death)  
Major findings: Otitis Media PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy g/a  
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? \_\_\_\_\_ (c) Means of injury O' MD  
23. Signature Bill Murray (M. D. or other) O' MD  
Address Hannibal, Mo. Date signed 5-21-46

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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 George T. Bond  
Licensed Embalmer No. 4373  
P. O. Address Hennibal, 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.**