

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
STANDARD CERTIFICATE OF DEATH

State File No. 27521

Registration District No. 155

Primary Registration District No. 5579

Registrar's No. 121

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Alba
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Alba, Missouri
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 40 years
(Specify whether years, months or days)

In this community 40 years
years, months or days

3. (a) PRINT FULL NAME MYRTLE JANE ROSE

3. (b) If veteran, name war none

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 Alfred Rose

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

7. Birth date of deceased July 30 1880
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>66</u>	<u>0</u>	<u>10</u>	hr. <u>---</u> min.

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

10. Usual occupation at home

11. Industry or business ---

MOTHER FATHER

12. Name Clark W. Rider

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

14. Maiden name Delia C. Earl

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

16. (a) Informant Mrs. Roy Hendrickson

(b) Address 422 Pine, Carthage, Mo.

17. (a) burial (Burial, cremation, or removal)

(b) Date thereof Aug. 14, 1946
(Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Knell Mortuary

(b) Address Carthage, Missouri

19. (a) AUG 13 1946 (Date received local registrar)

(b) G. L. J. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. -----
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country. -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 10
year 1946 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from April 1, 1946 to Aug 10, 1946
that I last saw her alive on August 10, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial failure

Due to tuberculosis

Duration 36 hrs

Due to ---

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

Major findings: ---

-Of operations ---

Of autopsy ---

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)

(c) Means of injury ---

23. Signature Glenn R. Oney (M. D. or other) DO

Address Alba, Mo. Date signed 8/12/46

46-8-689

01143

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.....

Emmaline

Licensed Embalmer No.....

391

P. O. Address.....

Carthage

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.