No. 2
M—5-43
5-17-39
1 X36671

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. 30745

FILED OCT 10 1946

Registration District No. _____ Primary Registration District No. 3127 Registrar's No. 153

**1. PLACE OF DEATH:**

(a) County: Jasper

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

(c) Name of hospital or institution: 319 South Oronogo St. /
(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: 40 years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Jasper 47

(c) City or town: Webb City 6
(If outside city or town limits, write "RURAL")

(d) Street No.: 319 South Oronogo St. 2
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME: Rosa Hargis

3. (b) If veteran, name war _____

3. (c) Social Security No.: none

4. Sex: F. /

5. Color or race: W.

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: November (Month) 28 (Day) 1875 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 10 | 1 | hr. _____ min. |

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

10. Usual occupation: at home

11. Industry or business _____ /

FATHER
12. Name: D. W. Johnson
13. Birthplace: Tenn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Sarah Virginia Burkes
15. Birthplace: Webster County (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Son: Dolph Hargis
(b) Address: Webb City, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 10/1/46 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Hope Cemetery

18. (a) Signature of funeral director: Hedge-Lewis
(b) Address: Webb City, Mo.

19. (a) OCT. 5. 46 (Date received local registrar) (b) [signature] (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 29 year 1946 hour 3:30 minute A. M.

21. I hereby certify that I attended the deceased from 9/25 1946 to 9/29 1946 that I last saw her alive on 9/29 1946 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 4 days |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations: 83A
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 0

23. Signature: [signature] M.D. (M. D. or other)
Address: Webb City, Mo. Date signed 10/4/46.

157

(Licensed Embalmer's Statement on Reverse Side)

46-9-844

DEC 10 1946

## 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. 2859

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.**