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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED OCT 8 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30701  
State File No. \_\_\_\_\_  
Registrar's No. 34

Registration District No. \_\_\_\_\_ Primary Registration District No. 5286

1. PLACE OF DEATH:  
(a) County Clark  
(b) City or town Wyaconda town  
(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) 3  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 10 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State unknown (b) County ✓  
(c) City or town unknown  
(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 Rosell Washington  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 18, 1947  
year \_\_\_\_\_ hour 11 minute 45 P.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.

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

Immediate cause of death \_\_\_\_\_  
Due to Struck by Sante Fe train about one block west of last street crossing at Wyaconda  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address Remora

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29-47  
(Month) (Day) (Year)

(c) Place: burial or cremation Under the bush

18. (a) Signature of funeral director in the pocket

(b) Address 9/29-47

19. (a) 9/29-47 (Date received local registrar) (b) J. P. Andrus (Registrar's signature)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
Major findings: Of operations \_\_\_\_\_  
Of autopsy 10" inh

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Sept. 18, 1947

(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) \_\_\_\_\_ (b) Means of injury \_\_\_\_\_

23. Signature Perry J. Boston (M. D. or other) 3  
Address Kalooka, Mo Date signed 9-29-47

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

JAN 10 1950

RECEIVED  
District Health Officer No. 10  
District File Number 10-47-136  
Date Filed OCT-7-1947

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 Albert C Gerth

Licensed Embalmer No. 4257

P. O. Address Memphis 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.