

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36178

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 360

1. PLACE OF DEATH a. COUNTY <u>ADAIR</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town OR <u>KIRKSVILLE</u> township) c. LENGTH OF STAY (in this place) <u>80 DAYS</u>		a. STATE <u>Mo</u>	b. COUNTY <u>Sullivan</u>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>COMM. NURSING HOME #1</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>MILLAN</u>	d. STREET ADDRESS (If rural, give location) <u>1</u>

3. NAME OF DECEASED (Type or Print)	a. (First) <u>James Absalom</u>	b. (Middle) <u>Roseberry</u>	c. (Last) <u>ROSEBERRY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 5 1949</u>
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5. SEX <u>MO</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 2</u>	8. DATE OF BIRTH <u>5-21-78</u>	9. AGE (In years last birthday) <u>71</u> IF UNDER 1 YEAR Months <u>6</u> Days <u>14</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Illinois - Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
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13a. FATHER'S NAME <u>John Roseberry</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Powers</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>John Cochran</u>	ADDRESS <u>Millan Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MEDULLARY FAILURE</u>		<u>1 hr</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>CEREBRAL HEMORRHAGE</u>		<u>3 weeks</u>
DUE TO (c) <u>ARTEROSCLEROSIS</u>		<u>years</u>	<u>331X</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from NOV 28, 1949, to DEC 5, 1949, that I last saw the deceased alive on DEC 4, 1949, and that death occurred at 3:00 A. M., from the causes and on the date stated above.

23a. SIGNATURE <u>M.T. Gutenschn</u> (Degree or title) <u>D.O.</u>	23b. ADDRESS <u>Kirksville, Mo</u>	23c. DATE SIGNED <u>12-5-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-6-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oakwood</u>	24d. LOCATION (City, town, or county) (State) <u>Illinois Mo</u>
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DATE REC'D BY LOCAL REG. <u>12-8-49</u>	REGISTRAR'S SIGNATURE <u>Kate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Schreiner</u> ADDRESS <u>Millan Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

DEC 1 1949  
District Health Officer No.

District File Number 12-49-2

Date Filed DEC 1 1949

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 2667

P. O. Address Wulau - Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.