No. 300
10-48

FILED SEP 29 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29801

BIRTH NO. _____ REG. DIST. NO. 75 PRIMARY REG. DIST. NO. 3015 Registrar's No. 70

251

1. PLACE OF DEATH
a. COUNTY Clinton
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cameron
c. LENGTH OF STAY (In this place) 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 700 E, 2nd, St,

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Clinton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cameron 0257
d. STREET ADDRESS (If rural, give location) 700, E, 2nd, St, 0

3. NAME OF DECEASED (Type or Print)
a. (First) Julia
b. (Middle)
c. (Last) Roloson

4. DATE OF DEATH (Month) Sept, (Day) 11 (Year) 5

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Sept, 16, 1877
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR: Months 11, Days 27 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Mo, 0
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME John Wolf
13b. MOTHER'S MAIDEN NAME Charlotte Smith
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. XXXXX
17. INFORMANT'S SIGNATURE OR NAME Rolla Roloson Lawrence Kans, ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinatosis of viscera

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cancer sigmoid
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ✓

INTERVAL BETWEEN ONSET AND DEATH: Nov. 1950

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 153X
20. AUTOPSY? YES ☐ NO ☒

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 31, 1951, *to* 11th Sept, 1951, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Glenn Johnson MD (Degree or title)
23b. ADDRESS Maysville Mo
23c. DATE SIGNED 9/12/51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-13-51
24c. NAME OF CEMETERY OR CREMATORY Fairport
24d. LOCATION (City, town, or county) Fairport Mo, (State)

DATE REC'D BY LOCAL REG. 9-19-51
REGISTRAR'S SIGNATURE Winifred W. Moser 340
25. FUNERAL DIRECTOR'S SIGNATURE John Brown Maysville Mo ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
SEP 24 1951
DISTRICT
HEALTH OFFICE
CAMERON, MO.

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.....

.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No. 3933

P. O. Address Maysville 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.