V. S. No. 2
10M—8-43
Rev. 5-17-39
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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

FILED APR 5 1945

State File No. 10800

Registration District No. 349 Primary Registration District No. 6180 Registrar's No. 1

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Rural Morristown
(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)
(d) Length of stay: In hospital or institution — In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Sullivan
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Rose Ann Straley
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife George B.
6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased 6 (Month) 10 (Day) 1868 (Year)
8. AGE: Years 76 Months 9 Days 15 If less than one day ___ hr. ___ min.
9. Birthplace Sullivan Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name James Bunch
13. Birthplace (City, town, or county) Indiana (State or foreign country)
MOTHER 14. Maiden name Harriett Davis
15. Birthplace (City, town, or county) Don't know (State or foreign country)
16. (a) Informant Vern Straley
(b) Address Browning Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar (Month) (Day) 45 (Year)
(c) Place: burial or cremation Baker Cemetery
18. (a) Signature of funeral director Glenn E. Kent & Son
(b) Address Green City Mo
19. (a) 4-2-1945 (Date received local registrar) (b) Laura Shaw deputy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 25 year 1945 hour 6 minute A. M.
21. I hereby certify that I attended the deceased from August 31, 1943, to Mar 17, 1945, that I last saw her alive on Mar 17, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	Feb. 1944
Due to General Arteriosclerosis	1943
Due to Senility	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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

23. Signature [illegible] (M.D. or other) D.C.
Address Milan Mo Date signed 3-45

1351

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 4
District File Number 4-45-558
Date Filed APR 4 1945

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 Archie W Wade

Licensed Embalmer No. 3037

P. O. Address Greensburg Ind

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.