

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37414

State File No.

Registrar's No. 68

FILED DEC 12 1947

Registration District No.

Primary Registration District No. 4110

1. PLACE OF DEATH:

(a) County Chariton
(b) City or town Salisbury
(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 _____ (Specify whether years, months or days) 53 yrs

3. (a) PRINT FULL NAME John Franklin Roling

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race White 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 Feb 29 1864
(Month) (Day) (Year)

8. AGE: Years 83 Months 8 Days 22 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business Implement Machine

12. Name Bernard Roling

13. Birthplace Germany

14. Maiden name Magdalene Winkler

15. Birthplace Germany

16. (a) Informant's own signature John Roling

(b) Address Salisbury Mo

17. (a) Burial (b) Date thereof 11-24-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cemetery

18. (a) Signature of funeral director John Winkler

(b) Address Salisbury Mo

19. (a) 11/22/47 (b) John Winkler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton
(c) City or town Salisbury
(If outside city or town limits, write "RURAL") _____
(d) Street No. _____ (If rural, give location) _____
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21
year 1947 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from _____

_____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

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) Accident

(b) Date of occurrence November 21, 1947

(c) Where did injury occur? Salisbury Chariton Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In public place

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. A. West (M. D. or other) _____

Address Memphis Date signed 11/27/47

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-11-47.....

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. 3842

P. O. Address Salisbury, Md

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, above space should be left blank.