JUN 4 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
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1. PLACE OF DEATH
County Scotland
Township Thompson
City ..... (No. ..... St. ..... Ward)
Registration District No. 808
Primary Registration District No. 6053
File No. .....
Registered No. 4

2. FULL NAME Rosa Angeline Clatt
(a) Residence. No. Arbela, Mo St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF August Clatt
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 6, 1863
7. AGE Years 62 Months 8 Days 8 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) Near Bonaparte
(STATE OR COUNTRY) Iowa

PARENTS
10. NAME OF FATHER Phillip Faass
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Jacobina Gang
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Mrs Luther Kennedy
(Address) Arbela Mo

15. FILED 4/14, 1928 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April-14 1928
17. I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to April 14, 1928 that I last saw her alive on April-13, 1928, and that death occurred, on the date stated above, at 1 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy - (Hemiplegia)
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No DATE OF ✓
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical signs
(Signed) Don Pierce, M. D
4/14, 1928 (Address) Gorin Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Gorin Cemetery
DATE OF BURIAL Apr. 16 1928
20. UNDERTAKER Geoth & Baskett
ADDRESS Gorin, Mo

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

MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Scotland — Registration District No. 812 — File No. .....

Township Thompson — Primary Registration District No. 6053 — Registered No. .....

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Rosa Angeline Clott

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W.	M.

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 6 - 1862.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	65	8	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 4/14, 1928 — O M Baker MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 14 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—E... should be carefully supplied. AGE shoul... CAUSE ... ns, so that it may be properly classified. ...XA... Y. PHYSICIANS should ... ent of OCCUPATION is very import...

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

RECORD

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