

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

Do not use this space.

36082

1. PLACE OF DEATH

County Taney
Township Oliver
City Branson, (No.)

Registration District No. 859
6130
Primary Registration District No.

File No. 33
Registered No.
St. Ward)

2. FULL NAME

William Rollston,

(a) Residence. No. St. Ward.
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-19-1923

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
✓ 1 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School Boy
(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)

10. NAME OF FATHER Percy Rollston,

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 Percy Rollston,
(Address) Branson. Mo.

15. FILED 10/24/29 P.A. Thornhill
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/23/29. 19

17. I HEREBY CERTIFY, That I attended deceased from Oct 9, 1929, to Oct 23, 1929, that I last saw him alive on Oct 23, 1929, and that death occurred, on the date stated above, at 10:29 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Urinary Infection
11:58
1:28 / 109 14 ds.
(duration) yrs. mos. 14 ds.

CONTRIBUTORY (SECONDARY) Toxicemia, blood
(duration) yrs. mos. 10 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

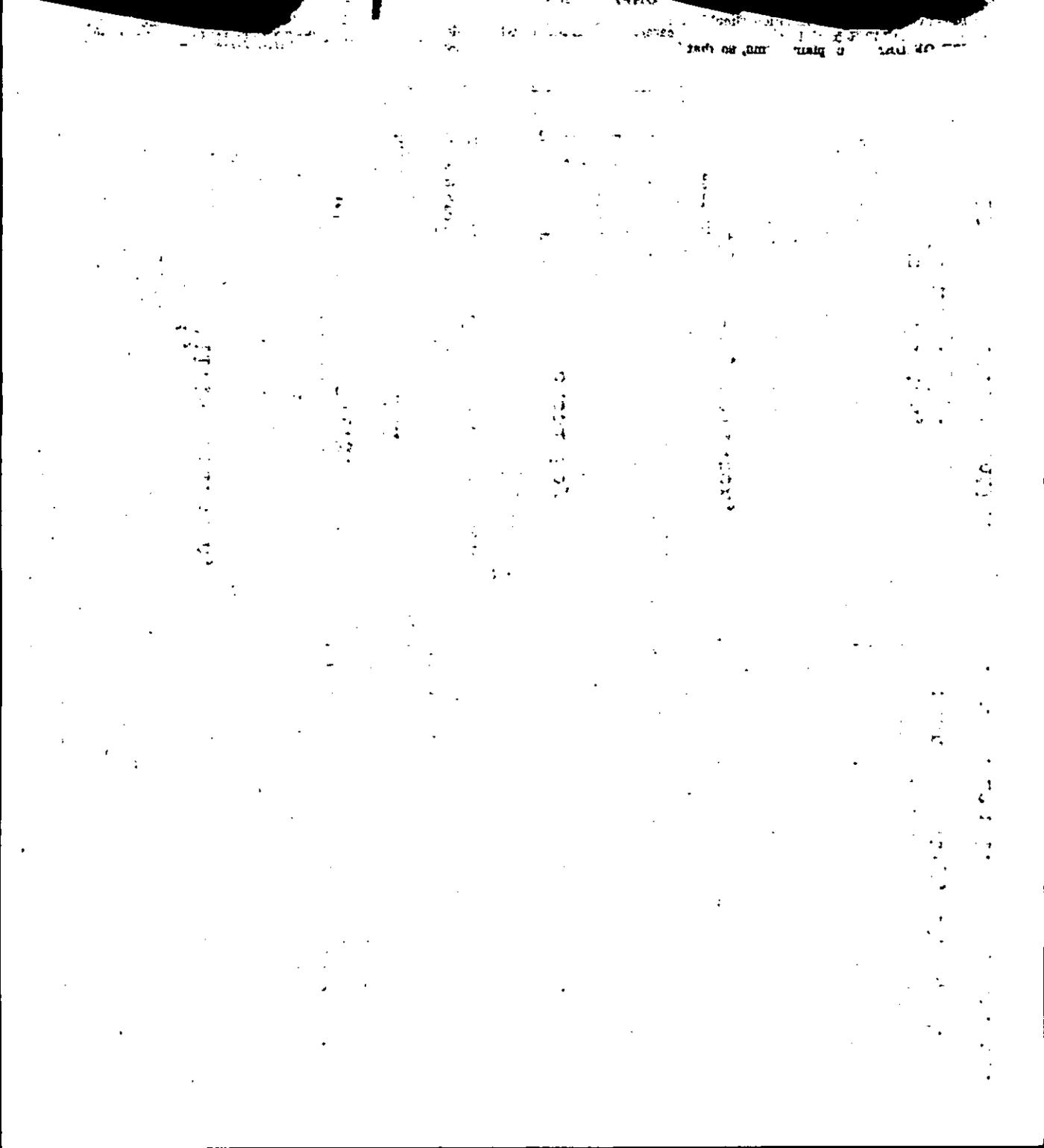
WHAT TEST CONFIRMED DIAGNOSIS Observation
(Signed) Spier Richardson M. D.
, 19 (Address) Branson Mo

*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 Branson Cemetry, DATE OF BURIAL 10/24/29. 19

20. UNDERTAKER H. O. Whelchel. ADDRESS Branson. Mo.

N. B. Every person should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCURRING Very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. 241



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Taney
Township Oliver
City (No.) St. Ward)

Registration District No. 859
Primary Registration District No. 6130

File No. 33
Registered No.

2. FULL NAME

William Rollston

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S.
(write the word)

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

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

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

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) Braunton Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Wm Rollston

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

12. MAIDEN NAME OF MOTHER Emily Cantrell

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

14. INFORMANT (Address)

15. FILED 10/24/29 Pa Thombree REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 13 - 1929

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:

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

20. UNDERTAKER ADDRESS

PHYSICIAN'S SIGNATURE SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. OCCUPATION SHOULD BE STATED EXACTLY. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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