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

Do not use this space.

40243

1. PLACE OF DEATH
County Franklin — Registration District No. 292
Township — Primary Registration District No. 4176
City New Haven (No. ..... St. ..... Ward)

File No. .....
Registered No. .....

2. FULL NAME Mrs Alice Rose
(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 24 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)
Female	Col.	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 5 1865

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
64	3	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(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) Warren Co. Mo

PARENTS
10. NAME OF FATHER Dont Know
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 Chas Rose Sr
(Address) New Haven Mo

15. FILED 12/31, 1929 J. Sheible REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 30 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1929, 19.., to Dec 30 1929 that I last saw her alive on Dec 27 1929, and that death occurred, on the date stated above, at 9 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
83 A
106 D
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Bronchitis
..... (duration) ..... yrs. 3 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? .....
(Signed) J F Goodrich, M. D.
12.31, 1929 (Address) New Haven 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	DATE OF BURIAL
New Haven Mo	Jan 1st 1930

20. UNDERTAKER	ADDRESS
L. C. Fertig	New Haven Mo

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.

JAN 10 1930

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