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

Do not use this space.

211

85

File No. .....

Registered No. 53

1. PLACE OF DEATH

County: Buchanan

Registration District No. .....

Primary Registration District No. 1001

Township: .....

City: St. Joseph, (No. ....., Missouri Methodist Hospital St. ..... Ward)

2. FULL NAME Infant Rother,

(a) Residence. No. ..... St., ... Ward. Craig, Missouri,
(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)
Male	White	Single,

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan'y. 12, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, 2 hrs. or ..... min.
0	0	0	

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

9. BIRTHPLACE (CITY OR TOWN) St. Joseph,
(STATE OR COUNTRY) Missouri,

PARENTS

10. NAME OF FATHER Edward Paul Rother,

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

12. MAIDEN NAME OF MOTHER Hazel Myrtle Barker,

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

14. INFORMANT Edward P. Rother
(Address) Craig, Missouri,

15. FILED JAN 13 1930 19 ..... John G. Ott REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 12. 19 30

17. I HEREBY CERTIFY, That I attended deceased from 1-12, 1930, to 1-12, 1930, that I last saw him alive on 1-12, 1930, and that death occurred, on the date stated above, at 8 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Born at 4½ months
Lack of Care (Premature)
159
158 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Premature Birth

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Craig Mo
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) W. L. Schaad, M. D.
1/12, 1930 (Address) St Joseph 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: Ashland Cemetery — DATE OF BURIAL: Jan. 13 19 30

20. UNDERTAKER: Heaton Belsole & Bowman — ADDRESS: 319 S. 10th.
Funeral Home

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD