

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

Do not use this space.
20431
~~20527~~
File No. _____
Registered No. 106
St. _____ Ward)

1. PLACE OF DEATH
County St. Francois Registration District No. 773
Township St. Francois Primary Registration District No. 6018A
City Near Farmington, Mo. St. _____ Ward)

2. FULL NAME Ella May Rose
(a) Residence. No. Sullivan, Mo. St. _____ Ward. (If nonresident, give city or town and State)
(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.

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 Unknown

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs.	or min.
	<u>40</u>	<u>7</u>	<u>7</u>		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. None
(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) Missouri

PARENTS	10. NAME OF FATHER <u>Unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>

14. INFORMANT Hospital Records
(Address) Farmington, Mo.

15. FILED 6-28-30 T. J. Robinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 28, 1930

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1930 to June 28, 1930
that I last saw her alive on June 28, 1930, and that death occurred, on the date stated above, at 10:00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
31 (duration) 3 yrs. 0 mos. 0 ds.
CONTRIBUTORY (SECONDARY) Insanity - Dementia Praecox
(duration) 15 yrs. 0 mos. 0 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 Clinical
(Signed) J. C. Tencher, M. D.
6-28-1930 (Address) Farmington, 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 City Cemetery **DATE OF BURIAL** June 30, 1930
20. UNDERTAKER Thos. P. Shaffer **ADDRESS** Sullivan

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

