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.

DEC'D SEP 12 1939

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

29142
Do not use this space.

1. PLACE OF DEATH
(a) County GREENE — Registration District No. 316
(b) Township — Primary Registration District No. 1290 — Registered No. 624
(c) City SPRINGFIELD — (d) Street No. Burge Hospital — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
230

2. PRINT FULL NAME Baby Ruth Evelyn Rost.
(a) Residence, No. — St. — Marshfield Mo
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ~~August 10 1939~~ St. Aug 10 1939

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
0	0	0	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Burge Hospital Springfield, Mo.

FATHER
13. NAME Mr. J.T. Rost
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER
15. MAIDEN NAME Inez Goodnight
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT Mrs. Maggie Goodnight
(ADDRESS) Marshfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Ebenezer DATE Aug 10 1939

19. FUNERAL DIRECTOR (NAME) McMahan
(ADDRESS) Marshfield Mo.

20. FILED Aug 10, 1939 Chas. A. George M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 10 - 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19.. to Aug 10, 1939
I last saw her alive on Aug 10, 1939. Death is said to have occurred on the date stated above, at 12:04 m. A.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Stillborn -	

Other contributory causes of importance:
Placental anomaly & Long Labor.

Name of operation No Date of
What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ....., 19....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) C. P. Macdonnell, M. D.
(Address) Marshfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.