

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.

MOV 24 1939

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

37070  
Do not use this space.

1. PLACE OF DEATH  
 (a) County ST. FRANCOIS 2 Registration District No. 93  
 (b) Township RANDOLPH 1 Primary Registration District No. 6094B  
 (c) City LEADWOOD (d) Street No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (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.

2. PRINT FULL NAME FRANK RONEY  
 (a) Residence, No. LEADWOOD St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX MALE 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 MYRTIL RONEY

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 31 19 80

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>58</u>	<u>9</u>	<u>2</u>	

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. W.P.A.  
 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) MO

FATHER	13. NAME <u>SAMUAL RONEY</u>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>MO</u>
MOTHER	15. MAIDEN NAME <u>RACHEL BLACKWELL</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>MO</u>

17. INFORMANT (ADDRESS) MYRTIL RONEY  
LEADWOOD MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE Outstchell DATE Oct 4 1939

19. FUNERAL DIRECTOR J.S. Boyer & Son  
(ADDRESS) LEADWOOD MO.

20. FILED 10/10 19 39 W.E. 9 '101  
Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 2 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 21 1939, to Oct 2 1939  
 I last saw him alive on Oct 2 1939. Death is said to have occurred on the date stated above, at 10:00 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral Thrombosis  
Hypertension  
Cardiovascular disease  
 Date of onset 9/30/39

Other contributory causes of importance: None

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 John W Hunt M. D.  
 (Signed) Leadwood MO  
 (Address)

**STATEMENT BY LICENSED EMBALMER**

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_

hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_

\_\_\_\_\_ L. E. \_\_\_\_\_

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 3845

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