FILED APR 18 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10004

Registration District No. 4 Primary Registration District No. 3001 Registrar's No. 55

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 10 years
years, months or days) 7 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. 915 E. Cottonwood
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME WESLEY DUANE ROSE
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex M
5. Color or race W.
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased May (Month) 26 (Day) 1929 (Year)

8. AGE: Years 10 Months 7 Days 10 If less than one day hr. min.

9. Birthplace Kirksville (City, town or county) Mo (State or foreign country)
10. Usual occupation Student
11. Industry or business —
FATHER 12. Name Alvy Leroy Rose
13. Birthplace (City, town, or county) Minn (State or foreign country)
MOTHER 14. Maiden name Thawnie James
15. Birthplace (City, town, or county) Mo (State or foreign country)
16. (a) Informant Corrinn James Lair
(b) Address Kirksville Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 8, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Highland Park
18. (a) Signature of funeral director W. C. Summers
(b) Address Kirksville Mo
19. (a) Mar. 15/40 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 6th year 1940 hour 10 minute 30 P.M.
21. I hereby certify that I attended the deceased from March 3, 1940 to March 6, 1940 that I last saw him alive on March 6, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute dilatation of heart	immediate
Due to Diphtheria	7 days
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature M. P. McCallum DO (M. D. or other)
Address Kirksville Mo Date signed 3-8-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 4-40-869
Date Filed APR 16 1940

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 W. E. Summers

Licensed Embalmer No. 2159

P. O. Address Kirksville Mo

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.)

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

S. No. 2B
1—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10004

Registration District No. 4 Primary Registration District No. 3001 Registrar's No. 55

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County: Adair

(b) City or town: Kirksville Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: Wesley Duane Rose

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife .....

6. (c) Age of husband, or wife, if alive ..... years

7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
10	7	10	hr. ..... min.

9. Birthplace ..... (City, town, or county) (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

12. Name: Alvey Dean Rose

13. Birthplace: Preston (City, town, or county) Minn (State or foreign country)

14. Maiden name: Flannie James

15. Birthplace: Adair Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant .....

(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) May-1-40 (Date received by local registrar) (b) Spencer L. Meeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Mar day: 6 year: 1940 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19...; that I last saw h... alive on ..... 19...; and that death occurred on the date and hour stated above.

Immediate cause of death ..... *Duration*

Due to .....

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....

Of autopsy .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) .....

(b) Date of occurrence .....

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....
(Specify type of place)

While at work? ..... Means of injury .....

23. Signature: M. P. McCallum M.D. (or other)

Address: Kirksville Mo Date signed .....

S-10004