DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 10 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32675

Registration District No. 797 Primary Registration District No. 4477 Registrar's No. 11

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

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Miami Township
(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 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Saline 97
(c) City or town Miami 0
(If outside city or town limits write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME LEWIS DANIEL ROLL
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M (1)
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Ellen Gertrude Roll
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept - 28 - 1864 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
76	11	9	hr. min.

9. Birthplace Ill. (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name unknown
13. Birthplace 9 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name unknown
15. Birthplace 9 (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Marvin Roll
(b) Address Miami Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof 9-9-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Calhoun Mo
18. (a) Signature of funeral director Fred Wilkinson
(b) Address Clinton Mo
19. (a) 9-7-41 (Date received by local registrar) (b) Mrs Gertrude Hisle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7 year 1941 hour 6 minute 15 A. M.
21. I hereby certify that I attended the deceased from 8/11/41 to 9-7 1941 that I last saw him alive on 8-11-1941 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Septicemia	8/11-41
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? (e) Means of injury
23. Signature B. H. Sullivan (M. D. or other) M.D.
Address Miami, Mo. Date signed 9/7/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-9-41

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 Fred Wilkinson

Licensed Embalmer No. 2478

P. O. Address Clinton 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.

No. 2B
-8-21-41
1 X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32675

Registration District No. 797 Primary Registration District No. 4477 Registrar's No.

1. PLACE OF DEATH:
(a) County: Saline
(b) City or town: Marshall
(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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Lewis D. Roll
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: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Sept 28 1864 (Month) (Day) (Year)
8. AGE: Years 76 Months 11 Days 7 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Septicemia	
Due to: absorption of pyrus from decubitus	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: 24	
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: O. H. Sullivan (M. D. or other)
Address Date signed

SUPPLEMENTARY