

1. PLACE OF DEATH: CALLAWAY  
 (a) County CALLAWAY  
 (b) City or town MOKANE  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Albert  
 (If not in hospital or institution, write street number or location) 1  
 (d) Length of stay: In hospital or institution 1  
 In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MISSOURI (b) County CALLAWAY  
 (c) City or town MOKANE  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM MADISON ROSE

MEDICAL CERTIFICATION

3. (b) If veteran, name war No. 3. (c) Social Security No. ✓

20. DATE OF DEATH: Month Nov. day 10<sup>th</sup>  
 year 1944 hour 10 minute 30 P. M.

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED

21. I hereby certify that I attended the deceased from April 1  
1944 to Nov. 16 1944  
 that I last saw him alive on Nov. 10<sup>th</sup> 1944  
 and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife FRANCES MAY ROSE 6. (c) Age of husband or wife if alive 75 years  
 7. Birth date of deceased OCT. 4 1865  
 (Month) (Day) (Year)

Immediate cause of death Angina Pectoris and Coronary insufficiency 8 mos.  
 Duration 1 yr.

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>1</u>	<u>6</u>	hr. _____ min. _____

Due to arteriosclerosis

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

Due to tumor in middle abdomen, apparently carcinoma  
 Other conditions carcinoma  
 (Include pregnancy within 3 months of death) 3 or 4 wks.

10. Usual occupation RETIRED FARMER

11. Industry or business \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.  
 Major findings: \_\_\_\_\_  
 Of operations AB  
 Of autopsy \_\_\_\_\_

MOTHER FATHER {  
 12. Name MATHEW ROSE  
 13. Birthplace PENN.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name DK  
 15. Birthplace DK  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elizabeth Bagley  
 (b) Address Mokane, Mo

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? \_\_\_\_\_

17. (a) BURIAL (b) Date thereof Nov. 12, 1944  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation MOKANE

18. (a) Signature of funeral director John Y. Maupin  
 (b) Address 712 Court St. Fulton, Mo

While at work? \_\_\_\_\_ (Specify type of place)  
 (c) Means of injury \_\_\_\_\_

19. (a) Nov. 12, 1944 (b) Wm. Williamson  
 (Date received local registrar) (Registrar's signature)

23. Signature Wm. Williamson (M. D. or other)  
 Address Mokane, Mo Date signed 11-12-44

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

RECEIVED

District Health Officer No. 9;

District File Number.....

Date Filed.....

12-11-44

**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.....

*Glen Y. Marpin*

Licensed Embalmer No. ....

2725

P. O. Address.....

Fulton, 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, fact should be so stated above.