

S. No. 2
M. 13
P. 13
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 4 1945

Registration District No. 100

Primary Registration District No. 5391

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Central Texas

(b) City or town Central Texas
(If outside city or town limits, write "RURAL" and name of townships)

(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 _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas 107

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

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Malissa T. Rolley

3. (b) If veteran, name war _____

3. (c) Social Security No. 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27 year 1945 hour 1 minute 0 M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife John Rolley 6. (c) Age of husband or wife if alive _____ years

Birth date of deceased April 18 1877
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____ 19____ to June 27 1945 that I last saw h. w alive on Mar 25 1945 and that death occurred on the date and hour stated above.

8. AGE: Years 68 Months 2 Days 9 If less than one day _____ hr. _____ min.

Immediate cause of death apoplexy

Due to Chronic nephritis

Due to _____

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

10. Usual occupation House work

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

Major findings: Of operations _____

Of autopsy 12/15

11. Industry or business _____

12. Name Neut waid

13. Birthplace _____

14. Maiden name Martha Hill

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Martha Taylor

(b) Address _____

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

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

(b) Date of occurrence _____

17. (a) Burial (b) Date thereof 6-29-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rocky Hill

(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? _____

18. (a) Signature of funeral director Lusbeck

(b) Address Licking

19. (a) 8-1-45 (b) John W. Taylor
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(e) Means of injury D

23. Signature Lusbeck (M. D. or other)

Address Licking Mo Date signed _____

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5.

District File Number 845-342

Date Filed 8-20-45.

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 *Erbert E Ferguson*

Licensed Embalmer No. *8945*

P. O. Address *Riching Ms*

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.