

No. 2
8-43
17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

13806

FILED APR 22 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. _____

Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
908 Locust St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community 8 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn ⁵⁹
(c) City or town Chillicothe ¹
(If outside city or town limits, write "RURAL") ²
(d) Street No. 908 Locust ⁰
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Ozella Roe

3. (b) If veteran, name war _____ 3. (c) Social Security No. 1

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Ross Roe 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 28, 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 3 17 ✓ hr. _____ min.

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

10. Usual occupation At home

11. Industry or business _____

12. Name John Wally
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Marion McQuary
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Fred Canfield
(b) Address Chillicothe, Mo.

17. (a) Burial (b) Date thereof 4/17/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wheeling, Missouri

18. (a) Signature of funeral director Donald Bondan

(b) Address Chillicothe, Missouri

19. (a) April - 16 - 46 (b) Frances B. Neill
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15
year 1946 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from Jan 30
14 to Apr 15 1946
that I last saw her alive on Apr 14 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion sudden

Due to unknown

Due to _____

Other conditions intermittent angina pectoris several
(Include presence within 3 months of death) 10 years

Major findings _____
Of operations _____

Of autopsy 12/10

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?

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature Emerson (M. D. or other) Apr 16
Address Chillicothe, Mo. Date signed 1946

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

171

(Licensed Embalmer's Statement on Reverse Side)

4-20-46

DISTRICT HEALTH OFFICE
Cameron, Mo.

APR 30 1946

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... *Wayne Stollin*
Licensed Embalmer No. *1164*
P. O. Address *Chillicothe 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.