

No. 2  
2-243  
5-17-39  
K31697

**FILED JUN 18 1947**

Registration District No. **167**

Primary Registration District No. **3621**

Registrar's No. **147**

1. PLACE OF DEATH:  
(a) County **KNOX**  
(b) City or town **RURAL - LYON**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: **75 yrs.** (Specify whether  
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MISSOURI** (b) County **KNOX** **521**  
(c) City or town **RURAL** **0**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2 1/2 MI. N. - HURDLAND** **0**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No) **0**  
If yes, name country

3. (a) PRINT FULL NAME **WALTER SCOTT ROSEBERRY**  
3. (b) If veteran, name war **✓** 3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **May** day **19** year **1947** hour **12:00** minute **19** P.M.  
21. I hereby certify that I attended the deceased from **May 19** 19**47** to **May 19** 19**47**  
that I last saw him alive on **May 19** 19**47** and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**  
6. (b) Name of husband or wife **JANE** 6. (c) Age of husband or wife if alive **76** years  
7. Birth date of deceased: **JUNE 25 1872**  
(Month) (Day) (Year)

Immediate cause of death **Coronary Artery Disease** Duration **3 years**  
**frail**

8. AGE: Years **74** Months **10** Days **25** If less than one day hr. min.

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations **MI**  
Of autopsy

9. Birthplace: **KNOX CO. MO**  
(City, town, or county) (State or foreign country)  
10. Usual occupation: **FARMER**

MOTHER FATHER  
11. Industry or business  
12. Name **JAMES WESLEY ROSEBERRY**  
13. Birthplace **UNKNOWN** **9**  
(City, town, or county) (State or foreign country)  
14. Maiden name **MARY HODGEN**  
15. Birthplace **UNKNOWN** **9**  
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Mr. Geo. Roseberry**  
(b) Address **Hurdland, Mo.**  
17. (a) **burial** (b) Date thereof **May 22, 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **2.0.0.F. HURDLAND**  
18. (a) Signature of funeral director **George W. Hurdland**  
(b) Address **Hurdland, Mo.**  
19. (a) **June 13, 47** (b) **Nellie S. Hurdland**  
(Data received local registrar) (Registrar's signature)

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) (b) Means of injury **2**  
23. Signature **Wm. W. Kasper** (M. D. or other) **P.O.**  
Address **Hurdland, Mo.** Date signed **May 24, 47**

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

RECEIVED  
District Health Officer No. 10  
License File Number 647698  
Date Filed JUN 16 1947

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 Geo B Essary Jr

Licensed Embalmer No. 3755

P. O. Address Hudson 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. JulyRegistration District No. 169Primary Registration District No. 5621Registrar's No. 147

## 1. PLACE OF DEATH:

- (a) County Knox  
 (b) City or town Rural  
 (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 \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)3. (a) PRINT FULL NAME Walter S. Roseberry

3. (b) If veteran, \_\_\_\_\_
- 
- name war \_\_\_\_\_

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

4. Sex
- M
5. Color or race
- W

6. (b) Name of husband or wife
- Eva Jane Parrish
- 
6. (c) Age of husband or wife
- 76
- alive
- yes

7. Birth date of deceased
- June 25 1907
- 
- (Month) (Day) (Year)

8. AGE: Years
- 74
- Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

## 10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_  
 19. (a) \_\_\_\_\_ (b) Nelle S. Humalt  
 (Date received local registrar) (Registrar's signature)

## 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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- March
- 19
- 47
- year \_\_\_\_\_
- 
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ 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?  
 \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_
- 
- Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-21470