

FILED JUN 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18804

State File No.

Registrar's No. 204

BIRTH NO. REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008

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

1. PLACE OF DEATH a. COUNTY CALLAWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Callaway	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FULTON		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mokane	
c. LENGTH OF STAY (in this place) 4 days		d. STREET ADDRESS (If rural, give location) State St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Callaway Hospital			

3. NAME OF DECEASED a. (First) MARY b. (Middle) W c. (Last) ROOTES			4. DATE OF DEATH (Month) (Day) (Year) JUNE 10, 1949		
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5. SEX Female		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED		8. DATE OF BIRTH JAN 28, 1861		9. AGE (In years last birthday) 88 IF UNDER 1 YEAR Months 4 Days 12 IF UNDER 1 HR. Hours Min. 	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Wm S. Kidwell		13b. MOTHER'S MAIDEN NAME Winifred Reed		14. NAME OF HUSBAND OR WIFE George F. Rootes	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. D.K.		17. INFORMANT'S SIGNATURE OR NAME Mr. James McClannahan ADDRESS Fulton Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none				INTERVAL BETWEEN ONSET AND DEATH 4 days years 331X	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **6/7, 1949**, to **6/10, 1949**, that I last saw the deceased alive on **6/9, 1949**, and that death occurred at **3:58 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Nancy Dwyer M.D. (Degree if title)		23b. ADDRESS Fulton, Mo.		23c. DATE SIGNED 6/10/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/12/49		24c. NAME OF CEMETERY OR CREMATORY Lebbell		24d. LOCATION (City, town, or county) (State) Lebbell, Mo.	
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DATE REC'D BY LOCAL REG. June 10-1949		REGISTRAR'S SIGNATURE Maretta Lawrence 428		25. FUNERAL DIRECTOR'S SIGNATURE Glen J. Morgan ADDRESS Fulton, Mo.	
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RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUN 16 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed *Walter J. Haines, Jr.*

Licensed Embalmer No. *4557*

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.