

FILED JUL 17 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22898**

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 276

1. PLACE OF DEATH a. COUNTY <u>BUTLER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>BUTLER</u>										
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>POPLAR BLUFF, MO. &amp; WIFE</u>		c. LENGTH OF STAY (in this place) c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>GULIN 0120</u>										
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>POPLAR BLUFF HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>GENERAL DEL.</u>										
3. NAME OF DECEASED (Type or Print) a. (First) <u>MILLAGE</u> b. (Middle) <u>ROSE</u> c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 1 1950</u>										
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APR 3 1872</u>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>79</u> <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 1 YEAR</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> </tr> <tr> <td></td> <td></td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR	IF UNDER 1 YEAR	IF UNDER 1 YEAR	Months	Days	Hours			Min.
IF UNDER 1 YEAR	IF UNDER 1 YEAR	IF UNDER 1 YEAR										
Months	Days	Hours										
		Min.										
11. BIRTHPLACE (State or foreign country) <u>CARMIA, ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>										
13a. FATHER'S NAME <u>JOE ROSE</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH SMITH</u>										
14. NAME OF HUSBAND OR WIFE <u>EDWIN ROSE</u>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. (If res. give war or dates of service) <u>NO.</u>	17. INFORMANT'S SIGNATURE OR NAME <u>CALIP ROSE CARRIER MIBBS</u> ADDRESS; <u>ILL.</u>										
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION										
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>										
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <u>Arteriosclerosis</u>										
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)										
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.												
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)										
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?										
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.												
23a. SIGNATURE <u>Wm. H. Johnson M.D.</u> (Degree or title)		23b. ADDRESS <u>Poplar Bluff Mo</u>	23c. DATE SIGNED									
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>JULY 3,</u>	24c. NAME OF CEMETERY OR CREMATORY <u>BROWNS CHAPEL</u>	24d. LOCATION (City, town, or county) (State) <u>BROSLEY MO.</u>									
DATE REC'D BY LOCAL REG. <u>July 3-1950</u>	REGISTRAR'S SIGNATURE <u>Wm. H. Johnson</u> <u>428</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Russell Lippert</u> ADDRESS										

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED  
JUL 13 1950

BUTLER CO. HEALTH CENTER

FILE No. 750-296

DEC 12 1955

*[Handwritten signature]*

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.

Student .....  
Student Embalmer

Signed *Blyford Lehman*

Licensed Embalmer No. *636 Ark.*

P. O. Address *Spring Ark.*

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.