

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

17080

1145
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1. PLACE OF DEATH
County Ray Registration District No. 743
Township Fishing River Primary Registration District No. 6237
City Thomas H. Roe (No. _____) St. _____ Ward _____

2. FULL NAME Thomas H. Roe
(a) Residence No. Farms St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 83 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. _____
Registered No. 10
St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 11 - 1846
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
83 6 22
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer Got emp.
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rayco Mo
10. NAME OF FATHER Thomas Roe
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ray
12. MAIDEN NAME OF MOTHER Jennie Odell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo
14. INFORMANT J R Roe (Address) Richmond
15. FILED May 6 1930 L. E. Ellis Mo REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 3, 1930
17. I HEREBY CERTIFY, That I attended deceased from July 1929 to May 3, 1930
that I last saw him alive on May 2, 1930 and that death occurred, on the date stated above, at 7:45 A. M.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Decompensated mitral Insufficiency
191
920 (duration) 2 yrs. 9 mos. 22 ds.
CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis (duration) 2 yrs. 9 mos. 22 ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS?
May (Signed) John J. Tracy M. D.
3, 1930 (Address) Excelsior Springs Mo
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Odell Rayco mo May 4 1930
20. UNDERTAKER ADDRESS
Herbert Hope Excelsior Springs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUN 27 1930

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