

FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31060**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3623**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **4410 Wornall Rd.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **55 Yrs.**
In this community **55 Yrs.**
years, months or days

3. (a) PRINT FULL NAME **Cora B. Roe**

3. (b) If veteran, name war **No** **8. (c) Social Security No.** **No**

4. Sex **Fe.** **5. Color or race** **Wh.** **6. (a) Single, widowed, married, divorced** **Widow**

6. (b) Name of husband or wife **Thos. Roe** **6. (c) Age of husband or wife if alive** **1854** years

7. Birth date of deceased **Nov. 19** **1854**
(Month) (Day) (Year)

8. AGE: Years **86x85** Months **9** Days **24** If less than one day **hr.** **min.**

9. Birthplace **Sheridan Co Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Home**

11. Industry or business

12. Name **Wm. Brewer**

13. Birthplace **Unknown Vir.**
(City, town, or county) (State or foreign country)

14. Maiden name **Cooper**

15. Birthplace **Unknown Vir.**
(City, town, or county) (State or foreign country)

16. (a) Informant **E. C. Roe**
(b) Address **3800 Chestnut**

17. (a) Burial (b) Date thereof **Sept. 16-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Elmwood**

18. (a) Signature of funeral director **Eylar Funeral Home**

(b) Address **1800 Linwood K.C. Mo.**

19. (a) Sept. 16, 1940 (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **4410 Wornall Rd.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **14** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Jan 1937** 19____ to **Sept 14** 19____; that I last saw her alive on **Sept 13** 19____ and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Pneumonia**
Due to **Ch. Nephritis** **Sept**
Due to **Hypertension** **10 yrs.**

Other conditions (Include pregnancy within 3 months of death) **131**

Major findings: Of operations _____
Of autopsy _____

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 **1**

23. Signature **G. D. Johnson, M.D.** (M. D. or other)
Address **Plaza and Bldg** Date signed **9-14-40**

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

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

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 Chas Wilks

Licensed Embalmer No. 2644

P. O. Address. 1800 Linwood

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, above space should be left blank.