. S. No. 2
I—11-10-39
v. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 34505

Registrar's No. 4021

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

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2618 Victor 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution -- (Specify whether
In this community 10 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Mo. 0
(If outside city or town limits write "RURAL")

(d) Street No. 2618 Victor
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME FRED H. ROSE

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Bertha

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased June 29th, 1878
(Month) (Day) (Year)

8. AGE: Years 62 | Months 3 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Mechanic 1

11. Industry or business Self 0

FATHER
12. Name William C. Rose
13. Birthplace ____ (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Lullie Hamilton
15. Birthplace ____ (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mrs. Claude Darbe,
(b) Address 4032 Agnes, K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19-40 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director C.H.Blackman & Son, Inc.
(b) Address 2825 Indep. Blvd. K.C.Mo.

19. (a) 10-19-40 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month ____ day 10-17-40
year ____ hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from 8:00 a.m., 19__, to ____, 19__;
that I last saw the deceased alive on ____, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death Deputy Coroner

Due to Acute pulmonary edema

Due to Chronic myocardial infarction

Due to Old & recent coronary occlusion

Other conditions ____
(Include pregnancy within 3 months of death)

94B

Major findings:
Of operations ____
Of autopsy Yes

Duration

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

23. Signature [signature] (M. D. or other)
Address K.C. Mo Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

## 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 V D Blackman

Licensed Embalmer No. 3639

P. O. Address K. C. 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, above space should be left blank.**