V. S. No. 2
0M—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 24, 1942

Registration District No. 99

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

32915

State File No. 3810

Registrar's No.

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5317 Charlotte Street 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ----- (Specify whether
In this community 49 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 5317 Charlotte Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ----- 0

48 2 8

3. (a) PRINT FULL NAME Mrs. Rose Bell Popp

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Mr. John Popp

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

7. Birth date of deceased June (Month) 21 (Day) 1869 (Year)

8. AGE: Years 73 Months 3 Days 23 If less than one day hr. min.

9. Birthplace Monroe (City, town, or county) Michigan 1 (State or foreign country)

10. Usual occupation At Home

11. Industry or business -----

FATHER
12. Name Anthony Chabanaw
13. Birthplace (City, town, or county) Unknown 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown 9 (State or foreign country)

16. (a) Informant Mrs. Hugh Dasbach
(b) Address 5317 Charlotte Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16, 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director D. H. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd.

19. (a) 10-15-42 (Date received local registrar) (b) M. M. Grove (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 14 year 1942 hour 12 minute 45 A.M.

21. I hereby certify that I attended the deceased from Sept 1 1942 to Oct 14 1942 that I last saw him alive on Oct 14 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocarditis	13 mo
Due to Diabetes	12 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 H. S. Prentiss (M.D. or other)
Address 900 Rialto Bldg. Date signed 10/14/42

(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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address 15 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, fact should be so stated above.

V. S. No. 2B
0M—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.....

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3810

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether years, months or days)
In this community.....

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

3. (a) PRINT FULL NAME Rose Bell Popp

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive.....years

7. Birth date of deceased June (Month) 21 (Day) 187 (Year)

8. AGE: Years 72. Months 3 Days 23. If less than one day ....hr. ....min.

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

10. Usual occupation.....

11. Industry or business.....

FATHER
12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....
(b) Address.....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) Apr 1, 1943 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month.....day.....
year.....hour.....minute.....M.

21. I hereby certify that I attended the deceased from.....
....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration
.....
.....
Due to.....
.....
Due to.....
.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
.....
Of autopsy.....
.....

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

23. Signature..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

April 1[illegible]

32915