

FILED NOV 19 1942

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **4205**

1. PLACE OF DEATH:

(a) County **Jackson, Kansas**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Menorah Hospital, 0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Since 10-20-42**
(Specify whether years, months or days) **as above**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **14**
(c) City or town **Kansas, Cowich 0**
(If outside city or town limits, write "RURAL")
(d) Street No. **-** (If rural, give location)
(e) Citizen of foreign country? **2** (Yes or No)
If yes, name country **2**

3. (a) PRINT FULL NAME **Nelson A. Bossing,**

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

4. Sex **Male 0** 5. Color or race **White** 6. (a) Single, widowed, married, **2 divorced, Widowed**
6. (b) Name of husband or wife **-** 6. (c) Age of husband or wife if alive **-** years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **76** Months **-** Days **-** If less than one day **-** hr. **-** min.

9. Birthplace **Canada,** (City, town, or county) **2** (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **-**

MOTHER FATHER { 12. Name **-**
13. Birthplace **4** (City, town, or county) (State or foreign country)
14. Maiden name **-**
15. Birthplace **1** (City, town, or county) (State or foreign country)

16. (a) Informant **Nelson Bossing,**

(b) Address **-**

17. (a) **Shipped** (b) Date thereof **11-11-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Downs, Mo.**

18. (a) Signature of funeral director **Stine & McClure,**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **11-11-42** (b) **M. M. Browne**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **10th**
year **1942** hour **2** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Oct 20,**
19 **42** to **Nov 10,** 19 **42**

that I last saw him alive on **Nov 10,** 19 **42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumigies**

Duration **6 wks**

Due to **Unknown**

Due to **1070**

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

Major findings: **Cardiac failure**

Of operations **None**

Of autopsy **Not done**

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 **Richard L. Sutton, Jr.** (M. D. or other) **M.D.**
Address **1102 Grand Ave** Date signed **11-11-42**

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

W. R. Stewart
11 R. M.

A 20
SW 28 X
C 2
3 2

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 *Leon H. Stewart*

Licensed Embalmer No. *4177*

P. O. Address *Tampa, Fla., Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 4205

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

1. PLACE OF DEATH:

(a) County
(b) City or town
(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
In this community
years, months or days)

3. (a) PRINT FULL NAME Nelson A. Rossing

3. (b) If veteran, name war... no 3. (c) Social Security No. none

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

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

7. Birth date of deceased Aug. 5, 1866
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 5 If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business retired

12. Name Louis Rossing

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

14. Maiden name Kathleen Fark

15. Birthplace M. J.
(City, town, or county) (State or foreign country)

16. (a) Informant Emma Heitschmidt

(b) Address Matoma, Kans.

17. (a) Removal (b) Date thereof
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sorsain, Mo.

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

(b) Address 111 25/42

19. (a) 11/25/42 (b) M. H. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kans. (b) County
(c) City or town Covert
(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.

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.....

Due to.....

Due to.....

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

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?
.....
(Specify type of place)

While at work? (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

TEMPORARILY SUPPLEMENTED

MOTHER FATHER

S-36111

1942