

S. No. 2
M-2-43
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30930

FILED SEP 21 1943

149

Registration District No. _____
Primary Registration District No. 1002

State File No. _____

Registrar's No. 3798

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:
515 N. Lawndale /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether

In this community 20 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁴⁸

(c) City or town Kansas City ⁵
(If outside city or town limits, write "RURAL")

(d) Street No. 515 N. Lawndale ⁸
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ ¹

3. (a) PRINT FULL NAME NETTIE M. ROSS

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Fe.

5. Color or race White

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

6. (b) Name of husband or wife Fred W.

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Dec. 24, 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

63 8 7 _____ hr. _____ min.

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

10. Usual occupation Homemaker

11. Industry or business _____

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Fred W. Ross

(b) Address 515 N. Lawndale

17. (a) Burial (b) Date thereof Sept. 3, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director C. H. Blackman & Son.

(b) Address Kansas City, Mo.

19. (a) 9-2-43 (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 1
year 1943 hour 7 minute A. M.

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

Immediate cause of death _____
Coronary Arteriosclerosis with
Chronic myocardial
infarction.

Other conditions _____
(Include pregnancy within 3 months of death) 940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy See Above

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? _____

Inc. _____
(Specify type of place) Means of injury _____

23. Signature Dr. E. J. Walker (M. D. or other) M.D.

Address 25 M. City Date signed 9/1/43

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

MOTHER FATHER

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 *W. H. Blackman*

Licensed Embalmer No. 2244

P. O. Address.....

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.