

FILED MAR 7 1945
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson
 (a) County Kansas City
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: K.C. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days (Specify whether
 In this community 60 YEARS years, months or days)

3. (a) PRINT NAME Victor Mrs. Caroline Roe
 FULL NAME
 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 MARRIED
 6. (b) Name of husband or wife MR. JOHN ROE 6. (c) Age of husband or wife if alive 75 years
 7. Birth date of deceased JULY 12 - 1874
 (Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 10 If less than one day
70 hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business

MOTHER FATHER { 12. Name ISAAC PARKER
 13. Birthplace Brown Co, OHIO
 (City, town, or county) (State or foreign country)
 14. Maiden name Caroline Shelton
 15. Birthplace Brown Co, Ohio
 (City, town, or county) (State or foreign country)

16. (a) Informant John Roe
 (b) Address 6039 Harrison

17. (a) BURIAL (b) Date thereof FEB. 24 1945
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ELMWOOD CEMETERY

18. (a) Signature of funeral director D. H. Newcomer, Secy
 (b) Address 1401 BRUSH CREEK BLDG.

19. (a) 2-24-45 (b) D. E. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City 110
 (If outside city or town limits, write "RURAL") 14
 (d) Street No. 6039 Harrison 3
 (If rural, give location) 4
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 22nd
 year 1945 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from 2-19-45, 19... to 2-22-45, 19...
 that I last saw h. or alive on 2-22-45, 19...
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular accident
 Due to _____
 Due to _____

Other conditions 83a
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy None

22. If death was due to external causes, fill in the following:
 (c) 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 Clark W. Seely, M.D. (M. D. or other)
 Address Med. Bldg. K.C. Gen. Hospital Date signed 2-23-45

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

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..... *H. C. Newcomb*.....
Licensed Embalmer No. *4043*.....
P. O. Address..... *K. C. 100*.....

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.