No. 2
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5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36362

FILED NOV 26 1945

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4634

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: General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1010 E. 11 St. 8
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) N
If yes, name country

3. (a) PRINT FULL NAME Georgia Roe
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex 1
5. Color or race
6. (a) Single, widowed, married, divorced 1
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 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation 0
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country) 0
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country) 0
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Richmond Mo
18. (a) Signature of funeral director Manaw Funeral Home
(b) Address Richmond Mo
19. (a) 11-9-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9 year 1945 hour 9 minute 5 A. M.
21. I hereby certify that I attended the deceased from Nov. 4 1945 to Nov. 9 1945 that I last saw her alive on Nov. 9 1945 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Multiple lung abscesses etiology unknown-Broncho-
Due to pneumonia
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

107

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Clark W. Gilliland (M. D. or other)
Address Med. Dir. Gen'l Hosp. Date signed 11-9-45

(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 A. W. Manzer

Licensed Embalmer No. 4157

P. O. Address Richmond

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.

S. No. 2B
I—8-21-41
X29288

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. 4634

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: Gen. Hosp. # 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

In this community lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Georgia Catherine Roe

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: James R. Roe

6. (c) Age of husband or wife if alive: 64 years

7. Birth date of deceased: May 28, 1912 (Month) (Day) (Year)

8. AGE: Years 33 Months 5 Days 11 If less than one day: hr. min.

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

10. Usual occupation: housewife

11. Industry or business:

MOTHER FATHER

12. Name: Frank Williams

13. Birthplace: Ray Co., (City, town, or county) Missouri (State or foreign country)

14. Maiden name: Eddie E. Acver

15. Birthplace: Lafayette Co., (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: James R. Roe

(b) Address: Richmond, Missouri

17. (a) removal (Burial, cremation, or removal) (b) Date thereof 11-11-45 (Month) (Day) (Year)

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

18. (a) Signature of funeral director: Munsur Funeral Home

(b) Address: Richmond, Mo.

19. (a) 11-9-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1946 hour minute M.

21. I hereby certify that I attended the deceased from, 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

36362

. S. No. 2B
M—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. 4634

SUPPLEMENTARY

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: Gen. Hosp. #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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(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 Georgia Catherine Roe.

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 (Month) (Day) (Year)

8. AGE: Years | Months | Days | 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) 11-9-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9 year 1945 hour 9 minute 05a M.

21. I hereby certify that I attended the deceased from Nov. 4, 1945 to 11-9, 1945 that I last saw her alive on 11-9, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Multiple lung abscesses (non specific probably aspiration in origin.)

Due to

Due to bronchial pneumonia.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 107

Of autopsy

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 Clark W. Seely (M. D. ~~or other~~)
Address Gen. Hosp. Date signed 11-9-45

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