

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37154

FILED DEC 9 1946

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

4969

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

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
(If not in hospital or institution, write street number & location)

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

In this community 1-Mo 24 days
(Specify whether 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. 1314 Askew
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Rosalpha Jean Rogers

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 Single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept. 29 1946
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 23
year 1946 hour 11²⁰ minute P M.

21. I hereby certify that I attended the deceased from Jan 19____, to _____ 19____;

that I last saw him _____ alive on _____ 19____;

and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>1</u>	<u>24</u>	hr. _____ min. _____

Immediate cause of death that bites of each, head + neck

Due to Hemorrhage

Due to stroke

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 188-8
19

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

10. Usual occupation None - Infant-

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Of autopsy no
History + Impression

11. Industry or business _____

MOTHER FATHER { 12. Name Frankie Eugene Rogers

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

14. Maiden name Ruth O. Bannon

15. Birthplace Kansas City Missouri
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(c) Accident, suicide, or homicide (specify) accident 120

(b) Date of occurrence 11-23-46

(c) Where did injury occur? 1314 Askew
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

16. (a) Informant Frankie Eugene Rogers

(b) Address 1314 Askew

17. (a) Burial (b) Date thereof Nov 26 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hill Cem.

While at work no (Specify type of place) (e) Means of injury that bites

23. Signature Frankie Rogers (M. D. or other) _____

Address 1424 24th Date signed 11-24-46

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn

19. (a) 11-26-46 (b) Theraldine Holme
(Date received local registrar) (Registrar's signature)

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..... *C. W. Wise*

Licensed Embalmer No. *2570*

P. O. Address..... *150 7th*

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.