

No. 2  
-12-45  
5-17-39  
I X47070

THE STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **27921**  
Registrar's No. **3708**

FILED SEP 8 1947  
Registration District No. **249**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City or town **Kansas City**  
(c) Name of hospital or institution: **Research Hospital**  
(d) Length of stay: In hospital or institution **7 days**  
In this community **as above**

3. (a) PRINT FULL NAME **MRS. MAGGIE ROUPE**  
3. (b) If veteran, name war **no.**  
3. (c) Social Security No. **no.**

4. Sex **female**  
5. Color or race **white**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Thomas N. Roupe**  
6. (c) Age of husband or wife if alive **80** years  
7. Birth date of deceased **January 10 1873**

8. AGE: Years **74** Months **7** Days **17**  
If less than one day **hr. min.**

9. Birthplace **Missouri**

10. Usual occupation **housewife**

11. Industry or business **X**

12. Name **James Mack Wilmott**  
13. Birthplace **Missouri**  
14. Maiden name **Mollie Miller**  
15. Birthplace **Missouri**

16. (a) Informant **T. N. Roupe**  
(b) Address **Harrisonville, Missouri**

17. (a) **removal**  
(b) Date thereof **8-27-47**

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

18. (a) Signature of funeral director **Stine & McClure**  
(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **8-29-47**  
(b) **Steraldine Stines**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Cass 19**  
(c) City or town **Harrisonville**  
(d) Street No. **0**  
(e) Citizen of foreign country? **no.**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Aug** day **27**  
year **1947** hour **0:2** minute **05 p. M.**  
21. I hereby certify that I attended the deceased from **Aug 20**, 1947, to **27 Aug 1**, 1947  
that I last saw him alive on **27 August**, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of stomach with spread.**  
Duration **Unknown**

Other condition **Pneumonia atelectasis 1-2 days**  
Major findings: **Carcinoma Stomach with spread**  
Of operation **46 hr.**  
Of autopsy **Same plus pneumonia & atelectasis**

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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place)  
(a) Means of injury  
Signature **Oliver J. Brown** (M. D. or other) **M.D.**  
Address **350 E. Armour Blvd** Date signed **8-27-47**

**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

*[Handwritten Signature]*  
.....  
Licensed Embalmer No. 1415-  
P. O. Address *[Handwritten 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.**