

FILED NOV 24 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38394

State File No.

Registrar's No.

Registration District No. 149

Primary Registration District No. 1002

4765

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. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 DAYS
In this community 10 YRS.
years, months or days

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. 2344 TERRACE 8
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

MARIE ROREX

(b) If veteran, name war No

(c) Social Security No. 493-12-1759

4. Sex FEMALE 3

5. Color or race NEGRO
6. (a) Single, widowed, married, divorced MARRIED

(b) Name of husband or wife A. J. ROREX

(c) Age of husband or wife if alive 59 years

7. Birth date of deceased DECEMBER 23, 1894
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>10</u>	<u>18</u>	hr. _____ min.

9. Birthplace PITTS KANSAS 1
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business _____

12. Name WINCHESTER CLARK 1

13. Birthplace TENNESSEE 1
(City, town, or county) (State or foreign country)

14. Maiden name CASSINDY DARBEY 1

15. Birthplace LOUISIANA 1
(City, town, or county) (State or foreign country)

16. (a) Informant A. J. ROREX (HUSBAND)

(b) Address 2344 TERRACE

17. (a) Burial (b) Date thereof 11/18/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 1729 Lydia Avenue

19. (a) 11-14-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 11,
year 1947 hour 6: minute 00 A. M.

21. I hereby certify that I attended the deceased from NOVEMBER 3,
1947 to NOVEMBER 8, 1947;
that I last saw her alive on NOVEMBER 11, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death DIABETIC ACIDOSIS Duration _____

Due to DIABETES MELLITUS

Due to _____

Other conditions FRACTURE OF FEMUR 1 1/2 yrs ago
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 01

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? _____

While at work _____ (Specify type of place)
(e) Means of injury 0

23. Signature [Signature] (M. D. or other) M.D.

Address GENERAL HOSPITAL NO. 2 Date signed 11/13/47

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

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 *J. James Manlove*
Licensed Embalmer No. *3994*
P. O. Address *2503 Highland*

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.