

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000

1. PLACE OF DEATH
a. COUNTY Buchanan

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY Buchanan

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph c. LENGTH OF STAY (In this place) unk.

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph

d. FULL NAME OF HOSPITAL OR INSTITUTION 416 So. 20th St. d. STREET ADDRESS (If rural, give location) 416 So. 20th St.

3. NAME OF DECEASED
a. (First) Addie b. (Middle) _____ c. (Last) Rohr

4. DATE OF DEATH (Month) (Day) (Year) March 21, 1952

5. SEX female 6. COLOR OR RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH unk. 1861 9. AGE (In years last birthday) 91 IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY own home 11. BIRTHPLACE (State or foreign country) unk. 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME unk. 13b. MOTHER'S MAIDEN NAME unk. 14. NAME OF HUSBAND OR WIFE Jacob Rohr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Mrs. Milton Kennard, 418 So. 20th, St. Joseph, Mo. ADDRESS _____

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Disease (arteriosclerotic) INTERVAL BETWEEN ONSET AND DEATH unknown

ANTECEDENT CAUSES
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Allergy

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK HOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Mar. 20, 1952 to Mar 21, 1952, that I last saw the deceased alive on Mar 20, 1952 and that death occurred at 6:15 p. m., from the causes and on the date stated above.

23a. SIGNATURE Wm. J. Ryan, M.D. (Degree or title) 23b. ADDRESS St. Joseph, Mo. 23c. DATE SIGNED 3-22-52

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 24b. DATE 3/24/1952 24c. NAME OF CEMETERY OR CREMATORY Mt. Mora Cemetery 24d. LOCATION (City, town, or county) (State) St. Joseph Missouri

DATE REC'D BY LOCAL REG. April 2, 1952 REGISTRAR'S SIGNATURE Carl C. Cauley 25. FUNERAL DIRECTOR'S SIGNATURE Heaton-Bowman Funeral Home ADDRESS St. Joseph, Mo.

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed W. E. Amour

Licensed Embalmer No. 4791

P. O. Address 319 Ave 10 St. Joseph, Mo

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.