

FILED AUG 23 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28498

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>313</u>			
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>1 week</u>		c. CITY OR TOWN <u>Sedalia</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>815-W. 3rd</u> <u>0804</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frederick</u> b. (Middle) <u>Granville</u> c. (Last) <u>Rose</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 16 1954</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Sept-19-1887</u>			
9. AGE (In years last birthday) <u>66</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. Pac. Shops</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Louisville Kentucky</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>James Rose</u>		13b. MOTHER'S MAIDEN NAME <u>Virginia Patchiff</u>		14. NAME OF HUSBAND OR WIFE <u>Blanche Richardson Rose</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>702616-1726</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Blanche Rose</u>		ADDRESS <u>Sedalia</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) <u>Cerebral Haemorrhage</u> ANTECEDENT CAUSES DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>arterio sclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Paralysis agitans</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>X</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>X</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>X</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>X</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>X</u>					
22. I hereby certify that I attended the deceased from <u>Aug 1, 1954</u> , to <u>Aug 16, 1954</u> , that I last saw the deceased alive on <u>Aug 16, 1954</u> , and that death occurred at <u>4:10</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>John Bee Kemmerer MD</u>				23b. ADDRESS <u>Sedalia MO</u>		23c. DATE SIGNED <u>8/18/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-19-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia MO</u>			
DATE REC'D BY LOCAL REG. <u>8-19-54</u>		REGISTRAR'S SIGNATURE <u>L. M. Coontz Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>McLaughlin Bros</u>		ADDRESS <u>Sedalia</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

AUG 25

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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.....  
Signature of Student Embalmer

Signed *James R. Ashen*

Licensed Embalmer No. *490*

P. O. Address *Sedalia,*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.