

Health, Welfare, Public Service

FILED JUL 8 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021674  
STATE FILE NUMBER 3045

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gen. Hospital</b>		Length of stay in lb <b>50 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>1611 Madison</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Stella</b> Middle <b>-</b> Last <b>Rose</b>			4. DATE OF DEATH Month <b>6</b> Day <b>21</b> Year <b>59</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-28-1880</b>	9. AGE (In years last birt day) <b>78</b>	10. F UNDER 1 YEAR Months <b>4</b> Days <b>20</b>	11. IF UNDER 24 HRS. Hours <b>11</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>James McPherson</b>	11. BIRTHPLACE (City and state or country) <b>Madison, Kansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>Alexander Standley</b>	13b. OTHER'S MAIDEN NAME <b>Sarah McPherson</b>	14. NAME OF HUSBAND OR WIFE <b>John Sherman Rose</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>487-10-7246</b>	17. INFORMANT <b>Mrs. Dorothy Fouts</b>	Address <b>1611 Madison, K.C. Mo</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic heart disease with</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>decompensation</b>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>4200</b>
20c. TIME OF INJURY Hour <b>12:00</b> Month <b>6</b> Day <b>21</b> Year <b>59</b> a.m. p.m.	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>General Hospital</b>	COUNTY	STATE
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21. I attended the deceased from **5-25-59** to **6-21-59** and last saw her alive on **6-21-59**  
Death occurred at **12:00 A.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Abraham Galperin</b>	22b. ADDRESS <b>General Hospital</b>	22c. DATE SIGNED <b>6-22-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>6-23-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
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24. FUNERAL DIRECTOR <b>Talent Funeral Homes (S) K.C. Mo</b>	ADDRESS <b>6-22-59</b>	25. DATE RECD. BY HEALTH REG. <b>6-22-59</b>	26. REGISTRAR'S SIGNATURE <b>New Marshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Abraham Galperin m. D. All diseases in Part I must be causally related.

**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 *B. E. Weir* .....

Licensed Embalmer No. *4075* .....  
P. O. Address *208 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.