

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D APR 17 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

9739
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 1345
 (c) City Kansas City (d) Street No. St. Mary's Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 35 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME Mrs. Florence A. Rouse
 (a) Residence, No. 3040 Agnes St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ernest E. Rouse

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 27, 1877

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
61 10 29

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At home
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri 0
 13. NAME John E. Scott 0
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri 0

MOTHER 15. MAIDEN NAME Eliza A. Williams
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT Ernest E. Rouse
 (ADDRESS) 3040 Agnes

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATE 3-28- 1939

19. FUNERAL DIRECTOR (NAME) Freeman Mortuary
 (ADDRESS) 104 W. 42nd St., K.C., Mo.

20. FILED Mar 28 1939 M. M. Brown
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 26, 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 1938 to Mar 26 1939
 I last saw her alive on Mar 26 1939 Death is said to have occurred on the date stated above, at 3:45 p.m.
 The principal cause of death and related causes of importance were as follows:
Halgkins Disease
72 B

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? X-Ray Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify George C. Lee M. D.
 (Signed) _____ (Address) 730 Prof Bldg X.C. Mo.

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.....

Licensed Embalmer No.....

P. O. 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, above space should be left blank.

Handwritten signature