

S. No. 2  
-11-10-39  
v. 5-17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 8483

MAR 17 1941

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 43

1. PLACE OF DEATH:

(a) County Verona  
(b) City or town Rural - Washington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital # 39  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 mo - 15 days  
(Specify whether  
In this community. Same  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 108  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2849 Jackson  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Clarence Rounds

3. (b) If veteran, name war None 3. (c) Social Security No. Don't know

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Della Scott Rounds 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased June 14, 1905  
(Month) (Day) (Year)

8. AGE: Years 35 Months 12 Days 14  
If less than one day  
- hr. - min.

9. Birthplace Kansas City Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Auto Mechanic

11. Industry or business Garage

12. Name Edward Rounds

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

14. Maiden name Maud  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Della Scott Rounds

(b) Address 2849 Jackson, Kansas City, Mo.

17. (a) Burial (b) Date thereof 2/3/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director Frank G. Ludwig

(b) Address Nevada, Mo.

19. (a) Feb. 3 1941 (b) Allen D. Hays  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 2  
year 1941 hour 9:00 minute A. M.

21. I hereby certify that I attended the deceased from Dec. 18, 1940 to Feb. 2, 1941;  
that I last saw him alive on Feb. 1, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Status Epilepticus  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to §5

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature Frank H. Jolly (M. D. or other) M.D.

#Address Nevada, Mo. Date signed 2-3-41

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

108  
0  
0

RECEIVED

District Health Officer No. 7,

District File Number 3-41-438

Date Filed 3-6-41

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

*Mark E. Eichen*

Licensed Embalmer No.

*2656*

P. O. Address

*Nevada, 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, above space should be left blank.