

S. No. 2
1-4441
5-17-39
PI X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27434

State File No.

FILED SEP 12 1941

Registration District No.

Primary Registration District No. 1002

Registrar's No. 3092

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: in hospital or institution 5 Days
(Specify whether years, months or days) 3 Weeks

In this community 0 years, months or days

3. (a) PRINT FULL NAME Rosanna M. Girard

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Female! 5. Color of race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife David Girard

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased October 14 - 1880
(Month) (Day) (Year)

8. AGE: Years 60 Months 10 Days 1 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name Eli Balthazor

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

14. Maiden name Melina Pellant

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

16. (a) Informant David Girard

(b) Address Chyde Kansas

17. (a) Removal (b) Date thereof 8-16-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joe Kansas

18. (a) Signature of funeral director John Butler Son

(b) Address 975 Benton St. C. Mo

19. (a) 9/16/41 (b) M. H. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Cloud

(c) City or town Chyde
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? ✓ (Yes or No)

If yes, name country 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15th year 1941 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from 8-8-41 19... to 8-15-41 19...
that I last saw her alive on 8-15-41 19...
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Dural Haematomia

Due to Surgical Fracture Skull

Due to Brain Tumor (meningioepithelioma)

Other conditions: 54B
(Include pregnancy within 3 months of death)

Major findings: 54B
Of operations: 54B

Of autopsy above 54B

Duration

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place) (c) Means of injury

23. Signature Russell W. Jones (M. D. or other) D

Address Chyde Date signed

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

2820

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. *3426 Mo*

P. O. Address *Kansas City Kansas*

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.