S. No. 2
—9-4-41
. 5-17-39
PI X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 10 1941

Registration District No. 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 37891

Registrar's No. 1134

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: State Hospital #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs. 5 Mos. 11 ds (Specify whether years, months or days)

In this community 2 yrs. 5 Months 11 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 11

(c) City or town Kansas City 1 (If outside city or town limits, write "RURAL")

(d) Street No. 1510 Wyandotte st. 7 (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William Roher

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Catherine

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

7. Birth date of deceased ? (Month) ? (Day) 1870 (Year)

8. AGE: Years 71 Months ? Days ? If less than one day hr. min.

9. Birthplace ? (City, town, or county) 0 Missouri (State or foreign country)

10. Usual occupation Chronic invalid

11. Industry or business

FATHER
12. Name No Information
13. Birthplace 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace 9 (City, town, or county) (State or foreign country)

16. (a) Informant Jackson, Lo.

(b) Address Hospital Records

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-41 (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cemetery

18. (a) Signature of funeral director Stacy Barry Funeral Home

(b) Address 218 South 10th St

19. (a) Nov. 26, 1941 (Date received local registrar) (b) W. J. Nestlebush (Registrar's signature) M

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23 year 1941 hour 9 50 minute A. M.

21. I hereby certify that I attended the deceased from 6-12, 1939, to 11-23-, 1941; that I last saw him alive on 11-23, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis - hypertension ?

Due to —

Due to —

Other conditions Deteriorated - congenital deformity - scoliosis (Include pregnancy within 3 months of death)

Major findings: Of operations —

Of autopsy —

97

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? (City or town) (County) (State)

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

While at work? (e) Means of injury 0

23. Signature T. T. O'Dell (M. D. or other) M. D.

Address St. Joseph. Date signed 11/24/41

(Licensed Embalmer's Statement on Reverse Side)

Was not embalmed

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 wit the above constitutes grounds for revocation of license.)

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