S. No. 2
M—1-4-41
v. 5-17-39
I X25390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26408

Registration District No. SILEC SED 11 10/49 Primary Registration District No. 1002 Registrar's No. 3288

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: KANSAS CITY GEN'L HOSP (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NONO 1 Day (Specify whether

In this community 1 DAY years, months or days)

2. USUAL RESIDENCE OF DECEASED: 17

(a) State Mo (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME ROBERT HOMAN

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex MALE

5. Color or race White

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife SUSAN HOMAN

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

7. Birth date of deceased APRIL 12TH 1857 (Month) (Day) (Year)

8. AGE: Years 85 — Months 4 Days 21 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name John Homan
13. Birthplace Indiana (City, town, or county) (State or foreign country)

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

16. (a) Informant Robt Homan

(b) Address Carrollton Mo

17. (a) ~~Burial~~ Removal (Burial, cremation, or removal) (b) Date thereof 9/5-42 (Month) (Day) (Year)

(c) Place: burial or cremation Carollton Mo

18. (a) Signature of funeral director Standley Fun'l Home

(b) Address Carollton Mo

19. (a) 9-4-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 3 year 42 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on Coronn , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary sclerosis Chronic fibrous myocarditis acute pulmonary edema.

Due to 94 w

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy see above

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)

Whilst at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address K.C. Mo. Date signed 9/4/42

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(Licensed Embalmer's Statement on Reverse Side)

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 Peter L. Engelman

Licensed Embalmer No. 4273

P. O. Address KC 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, fact should be so stated above.