S. No. 2
0M—2-43
5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

FILED JUN 24 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

20419

State File No. 2537

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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: General Hospital #2 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6/1 to 6/2/43 (Specify whether years, months or days)

In this community ? unknown

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 3121 E. 53rd Street
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME ROSA JACKSON

3. (b) If veteran, name war NO

3. (c) Social Security No. Dont Know

4. Sex Female

5. Color or race Negro 3

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

6. (b) Name of husband or wife unknown.

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

7. Birth date of deceased ? (Month) ? (Day) 1876 (Year)

8. AGE: Years 67 Months Days If less than one day hr. min.

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

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Dont Know

13. Birthplace Dont Know 9 (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Dont Know

15. Birthplace Dont Know 9 (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-5-43 (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director Flynn + Greenstreet

(b) Address 1819 E. 5th K C Mo

19. (a) 6-4-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2 year 1943 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from June 1, 1943 to June 2, 1943 that I last saw her alive on June 2, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Senility with Inanition — Duration

Due to

Due to

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? (Specify type of place)

While at work? (e) Means of injury

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

Address Gen. Hosp #2 - 600 E 22 Date signed 6-4-43

(Licensed Embalmer's Statement on Reverse Side)

OW

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 W. G. Flynn

Licensed Embalmer No. 72011

P. O. Address 1819 E. 15th

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.