

S. No. 2  
FORM-2-43  
5-17-39  
I X35697

24050

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 3316

ED AUG 11 1943  
Registration District No. 149

Primary Registration District No. 1002

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

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 Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo. 7 days  
(Specify whether years, months or days)

In this community 1 1/2 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 920 Paseo  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Alice Rosenkranz

3. (b) If veteran, name war XX

3. (c) Social Security No. No

4. Sex Fe

5. Color or race Wh

6. (a) Single, widowed, married, divorced 0 Sgl

6. (b) Name of husband or wife XX

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

7. Birth date of deceased July 12 1933  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>10</u>	<u>0</u>	<u>17</u>	____ hr. ____ min.

9. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business \_\_\_\_\_

12. Name William Rosenkranz

13. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Angelina Ruffino

15. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant William Rosenkranz

(b) Address 920 Paseo

17. (a) Burial (b) Date thereof 7-31-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director J. N. Wagner

(b) Address Kansas City, Mo.

19. (a) 7-30-43 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29  
year 1943 hour 3: minute 45 A. M.

21. I hereby certify that I attended the deceased from May 1 1943 to July 29 1943  
that I last saw her alive on July 28 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Decompensating Heart

Due to Rheumatic Heart

Due to 9502

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

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

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

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: E. J. Evans M.D. (M. D. or other)

Address 911 Waldheim Bldg Date signed 7/30-43

Duration \_\_\_\_\_

Physician \_\_\_\_\_

Underline the cause to which death should be charged statistically.

911 Hall Farm  
0848-11

**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 A. R. Hainscoper  
Licensed Embalmer No. 4159  
P. O. Address R. C. 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.**