

S. No. 2
M-2-43
7-5-17-39
1 X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32295

State File No. _____

Registrar's No. _____

FILED NOV 1 1943
Registration District No. _____

Primary Registration District No. 1002

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:
K. C. General Hospital No. 01
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether _____)

In this community 20 Yes
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 1712 Jefferson
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME O'Donald, Rose

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Fe

5. Color of race Wht

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

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

About 77 hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER

12. Name Unknown 9

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

14. Maiden name Unknown

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

16. (a) Informant William Ford

(b) Address 26th & Stearns Rd K.C.Mo.

17. (a) removal (b) Date thereof 10-6-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hill Cem K.C.Mo.

18. (a) Signature of funeral director Simmons F. Stone

(b) Address 1404 So 37 K.C. Mo.

19. (a) 10-7-43 (b) P.E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6th
year 1943 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from Sept. 26th 1943 to Oct. 6th 1943
that I last saw her alive on Oct. 6th 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia - Fracture of right femur (accidental fall in home)

Due to _____

Due to 186a

Other conditions 18
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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) Accident - 1223

(b) Date of occurrence Sept 26, 1943

(c) Where did injury occur? 186a (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)

23. Signature Amey R. Thorn (M.D. or other) _____

Address Lied. Dir. Gen'l Hosp. Date signed 10-7-43

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

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 with the above constitutes grounds for revocation of license.)

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