

S. No. 2
M-243
5-17-34
X3387

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33927

State File No.

Registrar's No. 4327

NOV 1 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: K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 hrs. 5 min
(Specify whether
In this community 40 yrs.
years, months or days)

3. (a) PRINT FULL NAME

Charles Romaine

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color of race White
6. (a) Single, widowed, married. 2 divorced Widower
6. (b) Name of husband or wife Elizabeth Romaine
6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased July 25, 1854
(Month) (Day) (Year)

8. AGE: Years 89 Months 2 Days 15
If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business
MOTHER FATHER { 12. Name Nathan T. Romaine
13. Birthplace New York
(City, town, or county) (State or foreign country)
14. Maiden name No Record
15. Birthplace No Record No Record
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph Romaine (son)
(b) Address 2425 Cherry St. C. Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-12-43
(Month) (Day) (Year)
(c) Place: burial or cremation Bashor Cemetery, Kans

18. (a) Signature of funeral director Thos. G. L. Porter
(b) Address 918 Brooklyn St. C. Mo.

19. (a) 10-11-43 (b) Dep C. Brown
(Date received local registrar) (Registrar's signature)

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. 2425 Cherry
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10th
year 1943 hour 1 minute 35 A. M.

21. I hereby certify that I attended the deceased from Oct. 9th 19 43 to Oct. 10th 19 43
that I last saw him alive on Oct. 10th 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of left hip (Accidental fall)
Duration

Due to 186a
Due to 18
Other conditions (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
(b) Date of occurrence Oct 9 1943 193
(c) Where did injury occur? 2425
(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) fall
23. Signature Dwney R. Thom (M. D. or other)
Address Med. Dir. Gen'l Hosp. Date signed 10-11-43

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 Ralph W. Runnels,
Licensed Embalmer No. 3860
P. O. Address Kansas City, 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.