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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 4472

No. 2

-2-43

5-17-39

I X35697

FILED NOV 1 1943

Registration District No. 149Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson,
 (b) City or town Kansas City,
 (c) Name of hospital or institution: Trinity Lutheran Hospital, 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 days, (Specify whether
 In this community 25 years (years, months or days)

3. (a) PRINT FULL NAME Mrs. Mammie S. Ross,

3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced. Married

6. (b) Name of husband or wife Harry C. Ross 6. (c) Age of husband or wife if alive. 58 years

7. Birth date of deceased January 16 1893
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 9 4 _____ hr. _____ min.

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

10. Usual occupation at home,11. Industry or business x12. Name John Kent13. Birthplace Unknown (City, town, or county) (State or foreign country)14. Maiden name Sarah Holt,15. Birthplace Missouri (City, town, or county) (State or foreign country)16. (a) Informant Harry C. Ross,(b) Address 6025 East 15th Ter., Kansas City, Mo.

17. (a) BURIAL (b) Date thereof 10-21-43
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Nevada, Missouri

18. (a) Signature of funeral director. Stine & McClure
 (b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 10-21-43 (b) N. E. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6025 East 15th Terrace,
 (If rural, give location)
 (e) Citizen of foreign country? no. (Yes or No)
 If yes, name country x

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 20th
 year 1943 hour 12:33 minute a. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

1 Epidural Hemorrhage (left cortex)

Due to Probable fall

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1860

Major findings: Of operations 1860

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 N. E. Brown (M. D. or other) _____Address Stine & McClure Date signed _____

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

MOTHER FATHER

Dr. Conover

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 E. M. Plank

Licensed Embalmer No. 1848

P. O. Address K. 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.