

FILED JAN 15 1944
Registration District No. **76**

Primary Registration District No. **3026**

Registrar's No. **318**

1. PLACE OF DEATH:
 (a) County **JACKSON**
 (b) City or town **INDEPENDENCE**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
INDEPENDENCE SANITARIUM & HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **36 HOURS**
(Specify whether)
 In this community.....
years, months or days

3. (a) PRINT FULL NAME **ANGELA RASSE**
 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 **INFANT**
 6. (b) Name of husband or wife **XXXX**
 6. (c) Age of husband or wife if alive **XXXX** years
 7. Birth date of deceased **DEC. 18 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 2hr.min.

9. Birthplace **INDEPENDENCE MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **NONE**

11. Industry or business **NONE**

12. Name **JOHN H. RASSE**
 13. Birthplace **MARSHALL MISSOURI**
(City, town, or county) (State or foreign country)
 14. Maiden name **VIRGINIA RUTH GREEN**
 15. Birthplace **INDEPENDENCE, MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant **JOHN H. RASSE**
 (b) Address **915 S. MAIN ST**

17. (a) **REMOVAL** (b) Date thereof **DEC. 21, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MARSHALL, MISSOURI**

18. (a) Signature of funeral director *[Signature]*
 (b) Address **815 W. MAPLE AVE.**

19. (a) **12-21-1943** (b) *[Signature]*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **JACKSON**
 (c) City or town **INDEPENDENCE**
(If outside city or town limits, write "RURAL")
 (d) Street No. **915 S. MAIN ST**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **20**
 year **1943** hour **3** minute **45** A. M.

21. I hereby certify that I attended the deceased from **Dec 18 to Dec 20, 1943**
 that I last saw her alive on **Dec 19, 1943**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Others of dyspnea followed by deep cyanosis & death**
 Due to **Unknown cause** **37 hrs.**

Due to **1600**

Other conditions **Possibly fast term ut. of babe 10 lbs 4 oz**
(Include pregnancies within 6 months of death)

Major findings:
 Of operations **careful autopsy by a pathologist failed to find birth injury or other cause of death.**
 Of autopsy **careful autopsy by a pathologist failed to find birth injury or other cause of death.**
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?
-

While at work? **-** (Specify type of place)
 (e) Means of injury **5**

23. Signature **J. N. Hill, M.D.** (M. D. or other)
 Address **1438 Halder Ave.** Date signed **12/20/43**

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

MOTHER FATHER

4
4

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.