S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

6297

State File No.

FILED FEB 18 1944

Registration District No. 167

Primary Registration District No. 1002

Registrar's No. 584

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: 1306 E-27 st 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 48 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3

(c) City or town Kansas City 6
(If outside city or town limits, write "RURAL")

(d) Street No. 1306 E-27 st
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Laura Bell Roop

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Femal

5. Color or race white

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

6. (b) Name of husband or wife William M Roop

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased Oct 16 -1867
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
76	3	15	hr. min.

9. Birthplace Indiana 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William Ball
13. Birthplace No Record 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Adeline Trullis
15. Birthplace No Record 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R.A. Snively

(b) Address 1306 E-27 st

17. (a) Removal (b) Date thereof Feb-5-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rockville Mo

18. (a) Signature of funeral director Mrs C L Forster

(b) Address 918 Brooklyn

19. (a) 2-4-44 (b) T E Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 1st.
year 1944 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from December 25, 1943, to Feb 1, 1944
that I last saw her alive on Jan 30, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Heart failure	20 min
Due to Cerebral Hemorrhage	30 days
Due to Hypertension	years
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy 83a'

PHYSICIAN

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?
(Specify type of place)

While at work? (e) Means of injury 2

23. Signature M. L. Fletcher, D.O. (M.D. or other)

Address 1103 E 47 KC Mo Date signed 2-2-44

(Licensed Embalmer's Statement on Reverse Side)

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.