

Registration District No. 149

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: No. 1
COLONIAL REST HOME 7611 WORNALL ROAD
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 DAYS
(Specify whether
In this community 47 years 4
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson
(c) City or town K.C.
(If outside city or town limits, write "RURAL")
(d) Street No. 3429 Colman Rd.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS ROSETTA C ARRONSMITH

3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced Widow
(b) Name of husband or wife George
(c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 3 1856
(Month) (Day) (Year)

8. AGE: Years 88 Months 7 Days 29
If less than one day _____ hr. _____ min.

9. Birthplace Saint Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER
12. Name Michel Chatrand
13. Birthplace Mo
14. Maiden name Ambria Johnson
15. Birthplace Mo

16. (a) Informant Mrs. M. Claude Nelson

(b) Address 3424 Coleman Rd

17. (a) Burial (b) Date thereof Oct 4 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hills

18. (a) Signature of funeral director D. H. Newcomer's son

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 10-4-44 (b) H. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 2ND
year 1944 hour 11 minute 00 P.M.
21. I hereby certify that I attended the deceased from 5-6-43
_____, 19____, to Oct 2nd, 1944
that I last saw h. er alive on Oct 2nd
and that death occurred on the date and hour stated above.

Immediate cause of death Dehydration Duration 4 hrs
Arteriosclerosis yes

Due to _____
Due to _____

Other conditions 97
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations No
Of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
accident, suicide, or homicide (specify) No

(b) Date of occurrence _____

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 P. M. Nunn (M. D. or other) _____

Address 1401 SW Blvd Date signed 10-3-44

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

361

2-5
1401. South West Blvd

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..... *Oscar Torrey*
Licensed Embalmer No. *7767*
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.