

FILED OCT 29 1944
199

Registration District No. **1002**

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
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days
(Specify whether
In this community unknown
years, months or days)

3. (a) PRINT FULL NAME Andrew Romer
3. (b) If veteran, name war no **3. (c) Social Security** No. none

4. Sex male **5. Color or** white **6. (a) Single, widowed, married,** single
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
alive _____ years

7. Birth date of deceased July 9 1887
(Month) (Day) (Year)

8. AGE: Years 56 Months 5 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Austral 4
(City, town, or county) (State or foreign country)

10. Usual occupation Dish washer

11. Industry or business _____

12. Name Rom.
13. Birthplace Austral 4
(City, town, or county) (State or foreign country)
14. Maiden name Marguerite Loshke
15. Birthplace Austral 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Anna Romer
(b) Address 535 Barnett St K.C. 12
17. (a) Burial mt Calvary L.C.H. **(b) Date thereof** Oct 21 44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation mt Calvary L.C.H.
18. (a) Signature of funeral director Parmentier Bros
(b) Address 12 C mo
19. (a) 10-21-44 **(b) N. E. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State mo (b) County Jackson
(c) City or town Kansas City mo 4
(If outside city or town limits, write "RURAL")
(d) Street No. 613 main st.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 17
year 1944 hour 8 minute 10 P.M.
21. I hereby certify that I attended the deceased from _____
_____ 19 to _____ 19
that I last saw him alive _____ Reputy Coroner _____ 19
and that death occurred on the date and hour stated above.

Immediate cause of death: Encephalomalacia
Due to _____

Other conditions: Acute Purulent Bronchitis
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy: See Above

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)
(a) Means of injury: _____
28. Signature A. E. Ueber (M. D. or other) M.D.
23 McCoy Date 10/20/44

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..... *Francis Walter*

Licensed Embalmer No. *2744*

P. O. Address..... *15. 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4227

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Rome, Andrew

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 57 Months Days If less than one day hr. min.

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

10. Usual occupation.....
11. Industry or business.....
12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) 11-28-44 (Date received local registrar) (b) J. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County.....
(c) City or town K6 (If outside city or town limits write "RURAL")
(d) Street No. 613 Main (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: MO Oct day 17
year..... hour..... minute..... 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.....

Far advanced bilateral pulmonary tuberculosis.

Due to.....
Due to.....

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

Major findings: Of operations 135
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 Albert E. Upsher (M. D. or other)
Address General Hospital Date 11-20-44

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

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

33392