S. No. 2
M—2-43
v. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 17 1945

Registration District No. 119

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5227

Primary Registration District No. 1002

Registrar's No. 573

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:
804 Kensington 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 64 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 804 Kensington 4
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Edward Stanton LaRose

3. (b) If veteran, name war No

3. (c) Social Security No. 490-16-1454

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased 3 (Month) 11 (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
70	10	22	hr. min.

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

10. Usual occupation Retired, Street Car Co. Employee

11. Industry or business

MOTHER FATHER

12. Name Jacob LaRose

13. Birthplace (City, town, or county) Iowa 1 (State or foreign country)

14. Maiden name Melinda J. Morris

15. Birthplace (City, town, or county) Kentucky 1 (State or foreign country)

16. (a) Informant Mrs. Edna Gammell

(b) Address 2403 Indiana

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

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

(b) Address Kansas City, Missouri

19. (a) 2-5-45 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 3rd.
year 1945 hour approx. 5 AM minute M.

21. I hereby certify that I attended the deceased from Feb 2, 1945 to Feb 3, 1945
that I last saw him alive on Feb 2, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Myocarditis	Unknown
Due to Unknown	
Due to	
Other conditions (Include pregnancy within 3 months of death) None	

93 D

Major findings:
Of operations X

Of autopsy X

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?

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

23. Signature Dr. Thomas E. Day (M.D. or other) M.D.

Address 4316 E 9th K.C. Mo Date signed 2-3-45

(Licensed Embalmer's Statement on Reverse Side)

Dr. F.E.Day
4316 East 9th. be o162

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 J. A. Henrich

Licensed Embalmer No. 3599

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.