

REC'D JUL 3 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2671

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

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: ST. JOSEPH HOSPITAL
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 2-DAYS
(Specify whether
In this community 25 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL") 3
(d) Street No. 3923 BALTIMORE AVENUE
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. ORA B ROACH

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 WIDOWED
6. (b) Name of husband or wife MR. George Roach 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased NOVEMBER 1 1864
(Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days 20 If less than one day
hr. min.

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

10. Usual occupation AT HOME

11. Industry or business _____

12. Name JOHN CRESS

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

14. Maiden name MARY ELLEN HOCKER

15. Birthplace INDIANAPOLIS INDIANA
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. DON E. WILLIAMS

(b) Address 3923 BALTIMORE AVENUE

17. (a) REMOVAL (b) Date thereof JUNE 23 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation INDIANAPOLIS, INDIANA

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

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 6-23-45 (b) Geraldine Helmer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 21ST
year 1945 hour 8 minute 50 P. M.

21. I hereby certify that I attended the deceased from Pathologist to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Intestinal obstruction
Due to Intestinal volvulus

Due to _____
Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ 1228
Of autopsy As above
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 0

23. Signature Eraine Sherwood (M. D. or other) _____
Address Pathologist Date signed 6-22-45

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..... *Emile M. Calhoun*

Licensed Embalmer No..... *3506*

P. O. Address..... *Kemo*

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.