S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23182

FILED JUL 30 1945

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 3022

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~~: K. C. General Hospital No. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or ~~institution~~ 1 mo. 22 days (Specify whether years, months or days)

In this community 30 YEARS

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")

(d) Street No.: 3617 So. Benton (If rural, give location)

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

If yes, name country: -----

3. (a) PRINT FULL NAME: Katherine Rose

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. CHARLES E. ROSE

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

7. Birth date of deceased: MARCH (Month) Unknown (Day) 1862 (Year)

8. AGE: Years 83 Months 4 Days ? If less than one day ____ hr. ____ min.

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

10. Usual occupation: Saleslady-Fur Dept.

11. Industry or business: Berkson's retired

MOTHER FATHER

12. Name: Unknown

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

14. Maiden name: Unknown

15. Birthplace: Atchison (City, town, or county) Kansas (State or foreign country)

16. (a) Informant: Mr. Floyd E. Hobson

(b) Address: 3617 South Benton

17. (a) CREMATION (Burial, cremation, or removal) (b) Date thereof: JULY-18-1945 (Month) (Day) (Year)

(c) Place: ~~burial or~~ cremation D.W. NEWCOMER'S SONS

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

(b) Address: 1401-BRUSH CREEK BLVD.

19. (a) 7-19-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18 year 1945 hour 4 minute 50 A. M.

21. I hereby certify that I attended the deceased from May 27, 1945, to July 18, 1945; that I last saw h. ar alive on July 18, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: See 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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Clark W. Seely M.D. (M.D. or other)

Address: Med. Dir. Gen'l Hosp. Date signed: 7-18-45

(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 Emile M. Calhoun

Licensed Embalmer No. 3506

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.