

**FILED** SEP 10 1945

Registration District No. ....

Primary Registration District No. ....

1002

Registrar's No. ....

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:  
General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 days  
(Specify whether  
In this community 1 yr -  
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")  
(d) Street No. 915 Paseo  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME

Rosa Dalman

3. (b) If veteran, name war no

3. (c) Social Security No. me

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Louis Dalman  
6. (c) Age of husband or wife if alive 1882 years  
7. Birth date of deceased Feb-15-1882  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27  
year 1945 hour 2 minute P M.

21. I hereby certify that I attended the deceased from August 22 1945 to August 27 1945  
that I last saw her alive on August 27 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of liver, spleen, kidney, cardiac dilatation  
Due to arteriosclerosis

Duration

Due to

Other conditions (Include pregnancy within 3 months of death) 52a

PHYSICIAN

Major findings: Of operations

Of autopsy See above

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?

White at work (Specify type of place) Means of injury  
23. Signature Clark W Seely MD (M. D. or other)  
Address Med. Dir. K. General Hospital

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

MOTHER FATHER

11. Industry or business.....  
12. Name Truggine Kristina  
13. Birthplace Iceland (State or foreign country)  
14. Maiden name Adalbjorn (State or foreign country)  
15. Birthplace Iceland (State or foreign country)  
16. (a) Informant Stephen Dalman  
(b) Address 915 Paseo  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-45  
(Month) (Day) (Year)  
(c) Place: burial or cremation Green Lawn  
18. (a) Signature of funeral director Wm Ch Foster  
(b) Address 918 Brooklyn  
19. (a) 8-31-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**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

*Joe B. Yoder*  
Licensed Embalmer No. *4172*

P.O. Address

*918 Brooklyn*

**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.

*K.C. Mo*