

FILED MAY 16 1946

Registration District No. 149

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: 4343 Locust Street
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution NO. (Specify whether
 In this community all her life years, months or days)

3. (a) PRINT FULL NAME Mrs. Lora Bullene Root

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

4. Sex female / 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Walter C. Root 6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased: November 1 1870
 (Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 1 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business X

12. Name Thomas B. Bullene

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

14. Maiden name Amorette Hickok

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

16. (a) Informant Mrs. Amorette Titus

(b) Address 4343 Locust, Kansas City, Mo.

17. (a) burial (b) Date thereof 5-6-46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 5-3-46 (b) Sheraldine Holmes
 (Date received local registrar) (Registrar's signature)

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. 4343 Locust Street, (If rural, give location)
 (e) Citizen of foreign country? NO. (Yes or No)
 If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2
 year 1946 hour 5:45 minute A. M.

21. I hereby certify that I attended the deceased from April 16 1946 to May 1 1946
 that I last saw her alive on May 1 1946
 and that death occurred on the date and hour stated above

Immediate cause of death: Cerebral Hemorrhage Duration 27 hr.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 830

Of autopsy _____

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) _____ (Specify type of injury)

23. Signature David B. Repperson (R. D. or M. D.)

Address 928 Prof. Bldg. Date signed 5/3/46

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

MOTHER FATHER

Dr. David B. Robinson

Joseph Brady

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..... *Robert H Reed*

Licensed Embalmer No. *3745*

P. O. Address..... *NC 7mo*

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.