

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
X 36671

DEPARTMENT OF HEALTH OF THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
STANDARD CERTIFICATE OF DEATH

27336

State File No. \_\_\_\_\_

**FILED** AUG 27 1946

Registration District No. 117

Primary Registration District No. 1002

Registrar's No. 3501

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 No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 hrs. 15 min.  
(Specify whether \_\_\_\_\_)

In this community unknown  
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. 2223 Quincy 8  
(If rural, give location)

(e) Citizen of foreign country? no 0  
(Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lois 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 Single

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

7. Birth date of deceased August 4, 1945  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 9  
year 1946 hour 5 minute 45 P. M.

21. I hereby certify that I attended the deceased from Aug 4 1946 to 8-9 1946  
that I last saw her alive on 8-9 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

8. AGE:

Years	Months	Days	If less than one day
<u>1</u>	<u>0</u>	<u>5</u>	hr. _____ min. _____

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation child

11. Industry or business \_\_\_\_\_

12. Name Rose

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) unknown

14. Maiden name Spizer

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

Major findings: Of operations \_\_\_\_\_

Of autopsy See above

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Record Clerk

(b) Address General Hospital No. 1

17. (a) Burial (b) Date thereof 8-13-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation buried

18. (a) Signature of funeral director Wm C. Spitzer

(b) Address City

19. (a) 8-13-46 (b) Geraldine Thomas  
(Date received local registrar) (Registrar's signature)

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 Wm W. Hart (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 8-13-46

(Licensed Embalmer's Statement on Reverse Side)

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

26176

*Dr. Buckner*

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**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.....

*not embalmed*, Registered Apprentice No. ....  
working under my personal supervision.

Signed *Am. A. Schuyler*.....

Licensed Embalmer No. *3089*.....

P. O. Address *KC 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.**