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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40833**  
**5239**  
Registrar's No. \_\_\_\_\_

**FILED DEC 24 1946**  
Registration District No. **179**

Primary Registration District No. **1002**

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:  
**2924 Park 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **5 yrs** 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. **2924 Park** (If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **James Wallace Shrou**  
(b) If veteran, name war **— no**  
(c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Dec** day **12** year **46** hour **8** minute **0** M.  
21. I hereby certify that I attended the deceased from **Dec 12** 19**46** to **Dec 12** 19**46**  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex **m** 5. Color or race **w**  
6. (a) Single, widowed, married, divorced **Widow**  
6. (c) Age of husband or wife if alive **—** years  
7. Birth date of deceased **Feb - 4 - 1859**  
(Month) (Day) (Year)

Immediate cause of death **Acute myocardial infarction** Duration \_\_\_\_\_  
Due to **Myocardium**  
Due to **Old age**

8. AGE: Years **87** Months **10** Days **8** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace **Ky** (City, town, or county) (State or foreign country)  
10. Usual occupation **Retired Farmer**  
11. Industry or business \_\_\_\_\_  
12. Name **David Shrou**  
13. Birthplace **Ky** (City, town, or county) (State or foreign country)  
14. Maiden name **Mary Atkins**  
15. Birthplace **Ky** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Mary Moyers**  
(b) Address **2924 Park H.C. Mo**  
17. (a) **Buried** (b) Date thereof **12-15-46** (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Blue Springs Mo**  
18. (a) Signature of funeral director **Mrs G D Webb, S.M.**  
(b) Address **Blue Springs Mo**  
19. (a) **12-13-46** (b) **Walter D. Holman** (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) (c) Means of injury \_\_\_\_\_  
23. Signature **P L St. Clair** (M. D. or other) \_\_\_\_\_  
Address **5242 St. John** Date signed **12/13/46**

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed RBW

Licensed Embalmer No. 2355

P. O. Address Blum Springs 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.**