

No. 2
-12-45
5-17-39
1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 1 1947
Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 1002

9360
State File No. 1346
Registrar's No. 1346

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 4 days (Specify whether
In this community 10 years years, months or days)

3. (a) PRINT FULL NAME Gertrude Rooks
3. (b) If veteran, name war no **3. (c) Social Security** No. none

4. Sex Female **5. Color or race** Wh. **6. (a) Single, widowed, married, divorced** Divorced
6. (b) Name of husband or wife Glenn Rooks **6. (c) Age of husband or wife if alive** _____ years
Birth date of deceased Feb. 15 1889 (Month) (Day) (Year)

8. AGE: Years 62 Months 58 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation house work

11. Industry or business _____

MOTHER FATHER
12. Name William Jasper
13. Birthplace Somerset Ky (City, town, or county) (State or foreign country)
14. Maiden name Ada Clark
15. Birthplace Decatur Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Frank Jasper
(b) Address Laredo, Mo

17. (a) Removal **(b) Date thereof** 3-22-47 (Month) (Day) (Year)

(c) Place: burial or cremation Laredo, Mo

18. (a) Signature of funeral director Mrs. C. K. Foster
(b) Address Rt. 2, Mo

19. (a) 3-22-47 **(b)** Thereldine 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. 1717 1/2 Prospect (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 22
year 1947 hour 1 minute 35 A.M.

21. I hereby certify that I attended the deceased from March 18, 1947 to March 22, 1947
that I last saw her alive on March 22, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Bilateral bronchopneumonia
Duration _____

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? _____

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** 3-22-47

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

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.....

Theron R. Redman

Licensed Embalmer No. *2737*

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.