

S. No. 2
M-5-43
v. 5-17-39
I X36571

FILED MAR 21 1947
Registration District No. **966**

Primary Registration District No. **4254**

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

1. PLACE OF BIRTH:

(a) County **Johnson**

(b) City or town **Smithville**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. _____ (Specify whether)

In this community **39 years**
years, months or days

3. (a) PRINT FULL NAME **JAMES A. ROACH**
Jennett B. Roach

3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex **M** **5. Color or race** **W**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife. _____ **6. (c) Age of husband or wife if** _____
alive _____ years

7. Birth date of deceased. **Jan 19 - 1881**
(Month) (Day) (Year)

8. AGE: Years **92** Months **1** Days **20** If less than one day _____ hr. _____ min.

9. Birthplace **Lebanon Mo. Penn**
(City, town, or county) (State or foreign country)

10. Usual occupation **clerk**

11. Industry or business. _____

12. Name **Solomon Roach**

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

14. Maiden name **Margaret Shannon**

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

16. (a) Informant **Mrs. Fatha Fair**

(b) Address: **Smithville Mo**

17. (a) Burial (b) Date thereof **Mar. 20 '47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Smithville**

18. (a) Signature of funeral director. **B. J. Faxon**

(b) Address **20 North 2nd Mo**

19. (a) Mar. 19-47 (b) **Ernest D. Beatty**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Johnson 51**

(c) City or town **Smithville Mo**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **18**
year **1947** hour **9** minute **15 P.M.**

21. I hereby certify that I attended the deceased from **Oct 1**, 1947 to **March 18**, 1947
that I last saw him alive on **March 18**, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Ch Myocarditis**

Duration _____

Due to _____

Due to _____

Other conditions **Enlargement of prostate gland**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy **937**

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) (2) Means of injury _____

23. Signature **W. H. ...** (M. D. or other) _____

Address **Smithville Mo** Date signed **Mar 19 47**

APR 29 1947

JUL 2 1948

JUL 9 1950

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. 1

working under my personal supervision.

Signed.....

B. F. Vanden

Licensed Embalmer No. 1592

P. O. Address *La Jolla, Cal*

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.