

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED AUG 26 1948

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3296

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: GENERAL HOSPITAL NO. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 DAYS (Specify whether)

In this community 39 YRS. (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. 1217 1/2 WEST 24th ST. 8
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME ROSA ROSS

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 10, year 1948 hour 4: minute 35 A. M.

21. I hereby certify that I attended the deceased from AUGUST 5, 19 48 to AUGUST 10, 19 48 that I last saw her alive on AUGUST 10, 19 48 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race NEGRO

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ORA ROSS 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased SEPTEMBER 11, 1894
(Month) (Day) (Year)

Immediate cause of death CEREBRAL VASCULAR ACCIDENT

Due to HYPERTENSIVE HEART DISEASE

Due to _____

8. AGE: Years Months Days If less than one day

53 10 29 hr. _____ min.

Other conditions GENERALIZED ARTERIOSCLEROSIS
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 93d

22. If death was due to external causes, fill in the following:

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name MOTE CAVENS

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

14. Maiden name ANN YARBOUGH

15. Birthplace UNKNOWN 4
(City, town, or county) (State or foreign country)

22. (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? _____

16. (a) Informant ORA ROSS (HUSBAND)

(b) Address 1217 1/2 WEST 24th ST.

17. (a) Burial (b) Date thereof 8/14/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Westlawn Cemetery

23. Signature [Signature] (M. D. or other) _____
Address GENERAL HOSPITAL NO. 2 Date signed 8/10/48

18. (a) Signature of funeral director [Signature]

(b) Address 1729 E. 4th Ave

19. (a) 8-13-48 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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.....

J. J. Manlove

Licensed Embalmer No.....

3944

P. O. Address.....

1503 Highland

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.