

FILED MAY 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16116
2119

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City 4</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>21 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>6300 Winner Road</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Woodland Nursing Home</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>EFFIE</u> b. (Middle) <u>MAY</u> c. (Last) <u>ROSE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 12 1949</u>		
5. SEX <u>fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Mar 30 1886</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Invalid</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Iola Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Frank Wilson</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>John W. Rose</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John W. Rose 6300 Winner Rd</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Due to (b) Arteriosclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331X</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1948 to May 12, 1949, that I last saw the deceased alive on May 12, 1949, and that death occurred at 9 A m., from the causes and on the date stated above.

23a. SIGNATURE <u>C.B. Rector</u> (Degree or title) <u>P.O. 2</u>	23b. ADDRESS <u>7204 Prospect</u>	23c. DATE SIGNED <u>5/13/49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5-14-1949</u>	24c. NAME OF CEMETERY OR CREMATORY (Ind. LOCATION (City, town, or county) (State) <u>Mt Washington Kansas City Mo</u>

DATE REC'D BY LOCAL REG. <u>5-14-49</u>	REGISTRAR'S SIGNATURE <u>Sheldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C.H. Blackman & Son, Inc Kansas City, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

D. Staley Jr.

Student Embalmer No. *274*

working under my personal supervision.

Signed.....
Student Embalmer

D. Staley

Signed.....

H. D. Blackman

Licensed Embalmer No. *3639*

P. O. Address.....
H. C. New

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.