

FILED SEP 22 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 30407

3861

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

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>IOWA</b> b. COUNTY <b>Floyd</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>KANSAS CITY</b> |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><b>CHARLES CITY</b>  |  |
| c. LENGTH OF STAY (In this place)<br><b>5 DAYS</b>   |  | d. STREET ADDRESS (If rural, give location)<br><b>X</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>ST. LUKE'S HOSPITAL</b>                        |  |  |  |

|                                     |                      |                        |                       |   |
|-------------------------------------|----------------------|------------------------|-----------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>Jo</b> | b. (Middle) <b>Ann</b> | c. (Last) <b>Rose</b> | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>SEPT. 10-1951</b> |
|-------------------------------------|----------------------|------------------------|-----------------------|---|

|                         |                                  |  |  |   |
|-------------------------|----------------------------------|--|--|---|
| 5. SEX<br><b>FEMALE</b> | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>NEVER MARRIED</b> | 8. DATE OF BIRTH<br><b>MARCH 20-1947</b> | 9. AGE (In years last birthday) <b>4</b><br>If under 1 year: Months _____ Days _____<br>If under 24 hrs: Hours _____ Min. _____ |
|-------------------------|----------------------------------|--|--|---|

|   |  |  |   |
|---|--|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CHILD</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br>--- | 11. BIRTHPLACE (State or foreign country)<br><b>Charles City, Iowa</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
|---|--|--|---|

|  |  |                                    |
|--|--|------------------------------------|
| 13a. FATHER'S NAME<br><b>WALTER ROSE</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Frances Mitchell</b> | 14. NAME OF HUSBAND OR WIFE<br>--- |
|--|--|------------------------------------|

|   |  |  |                                      |
|---|--|--|--------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> | 16. SOCIAL SECURITY NO.<br><b>NONE</b> | 17. INFORMANT'S SIGNATURE OR NAME<br><b>Frances Rose</b> | ADDRESS<br><b>Charles City, Iowa</b> |
|---|--|--|--------------------------------------|

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|---|--|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><b>75<sup>9</sup> D</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Branchopneumonia + Abscess of Congenital Cysts of the Lung</b>   |  |   |
|   | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____ |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Internal Hydracephalus</b>   |  |  |   |

|                        |                                  |   |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input 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) (m.) | 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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

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|--|--|------------------------------------|
| 23a. SIGNATURE <b>Richard Schaffer</b> (Degree or title)<br><b>Richard Schaffer M.D. (Pathologist)</b> | 23b. ADDRESS<br><b>St. Luke Hosp. K.C., Mo</b> | 23c. DATE SIGNED<br><b>9-10-51</b> |
|--|--|------------------------------------|

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> | 24b. DATE<br><b>SEPT 10 1951</b> | 24c. NAME OF CEMETERY OR CREMATORY<br>--- | 24d. LOCATION (City, town, or county) (State)<br><b>CHARLES CITY IOWA</b> |
|--|----------------------------------|---|---|

|  |  |  |  |
|--|--|--|--|
| DATE REC'D BY LOCAL REG.<br><b>9-10-51</b> | REGISTRAR'S SIGNATURE<br><b>Geraldine Holmes</b> | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>D. H. Newcomer's Sons</b> | ADDRESS<br><b>331 BRUSH CREEK KANSAS CITY, MO.</b> |
|--|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed..... *Basil O'Norey* .....

Licensed Embalmer No. *4724*

P. O. Address *Lakeland, Fla.*

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.