

FILED NOV 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37546**
4766

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 8 yrs		d. STREET ADDRESS (If rural, give location) 1220 Benton	
d. FULL NAME OF HOSPITAL OR INSTITUTION Osteopathic Hospital			

3240

3. NAME OF DECEASED (Type or Print) a. (First) Bessie b. (Middle) May c. (Last) Routh			4. DATE OF DEATH (Month) (Day) (Year) Nov 6 1951			
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed ✓	8. DATE OF BIRTH July 1 - 1889	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Lansing, Kansas		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Mike Fall	13b. MOTHER'S MAIDEN NAME Mattie Lehman	14. NAME OF HUSBAND OR WIFE John Routh
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Faye Fall, 1220 Benton, K. C. Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes Mellitus DUE TO (c) Pancreatic Atrophy		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Cancer of Uterus	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

260X

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 **9:30p** m., from the causes and on the date stated above.

23a. SIGNATURE D. A. HOBKINS (Degree or title) D. A. Hobkins D.O. Pathologist	23b. ADDRESS 2105 Independence Ave Kansas City Mo	23c. DATE SIGNED 11-7-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Nov 10 1951	24c. NAME OF CEMETERY OR CREMATORY Bonner Spgs. Cemetery	24d. LOCATION (City, town, or county) (State) Bonner Spgs. Kansas
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DATE REC'D BY LOCAL REP. 11-8-51	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Simmons K.C.K.
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

H. Simmons

Signed.....
Student Embalmer

Licensed Embalmer No. 3903

P. O. Address: KOR.

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.