

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18045**

FILED JUN 21 1954

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>611</u>		
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>40 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		e 117 c		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3206 Seneca St.</u>				d. STREET ADDRESS (If rural, give location) <u>3206 Seneca St.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>FLORENCE</u> b. (Middle) <u>M</u> c. (Last) <u>ROSECRANS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 10, 1954</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Feb. 3, 1863</u>		
9. AGE (In years last birthday) <u>91</u>		10. MONTHS <u>4</u>		11. DAYS <u>7</u>		12. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13a. FATHER'S NAME <u>James W. Gammill</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Landon</u>		14. NAME OF HUSBAND OR WIFE <u>War Hic Rosecrans</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Bernice Stoner, Nelson, Nebraska.</u>				
15. ADDRESS (Type or Print)		17. ADDRESS						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION								
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>						
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____						
II. OTHER SIGNIFICANT CONDITIONS		Fell at home on kitchen floor about 4-20-54 & was not found until 4-22-54, fractured left hip.						
19a. -DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION! <u>331 X F</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) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Joseph Buchanan Missouri</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Apr 20, 1954 ? m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell on kitchen floor</u>				
22. I hereby certify that I attended the deceased from <u>4-22, 1954</u> , to <u>6-10, 1954</u> , that I last saw the deceased alive on <u>6-9, 1954</u> , and that death occurred at <u>8:52 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>H. J. Mundy M.D.</u>			23b. ADDRESS <u>2801 Sacramento St. St. Joseph, Mo.</u>			23c. DATE SIGNED <u>6-11-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 12, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>June 17, 1954</u>		REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>		483		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clark</u> ADDRESS <u>Clark Funeral Home St. Joseph, Mo.</u>		

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 *Emuel Clark*

Licensed Embalmer No. 4235

P. O. Address *St. Joseph Mo.*

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.