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FILED JUN 22 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18932  
2461

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>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (In this place) <u>45 yrs</u>		Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2645 East 8th St.</u>			
e. STREET ADDRESS (If rural, give location) <u>2645 East 8th Street</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>DAVID</u>	b. (Middle) <u>E.</u>	c. (Last) <u>ROCHE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>6-7-55</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, 2. WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 10, 1885</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work during most of working life even if retired) <u>Retired Contractor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Pet. Wells</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Brooklyn, New York, U.S.A.</u>	12. CITIZENSHIP OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Michael H. Roche</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Powers</u>	14. NAME OF HUSBAND OR WIFE <u>Mary M. Roche</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, specify known) <u>No</u>	16. SOCIAL SECURITY NO. <u>494-12-3239</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mary E. Roche</u>	ADDRESS <u>2645 E. 8th - K.C. Mo.</u>
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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, asthma, 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) <u>Arteriosclerotic heart disease</u>		<u>3 years</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>42°</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 10-27, 1951, to 6-7, 1955, that I last saw the deceased alive on 6-4, 1955, and that death occurred at 11:50 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>T. Reid Jones</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>1107 Pryor Rd</u>	23c. DATE SIGNED <u>6.8.55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6/9/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary Cemetery</u>	24d. LOCATION (City, town or county) (State) <u>Kansas City, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>6-8-55</u>	REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	EMERALD DIRECTOR'S SIGNATURE <u>Shelley M. Kelley</u>	ADDRESS <u>6 E. 14th - K.C. Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
J. Reid Jones

*Dr. L. Reid Jones*  
*1107 Bryant Bldg*  
*W.C. 8848*  
*5*  
*Feb. - 1-5*

**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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No.....  
P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.