

FILED OCT 19 1955

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

33529
State File No. 4153

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 town) KANSAS City	c. LENGTH OF STAY (in this place) 9 yrs	c. CITY OR TOWN KANSAS City	d. 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 5550 CENTRAL STREET		e. STREET ADDRESS (If rural, give location) 5550 CENTRAL STREET	

3. NAME OF DECEASED (Type or Print) a. (First) CLARK b. (Middle) B c. (Last) ROSSER	4. DATE OF DEATH (Month) (Day) (Year) SEPT 21, 1955
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 2/22/19	9. AGE (In years last birthday) 36	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSISTANT TREASURER	11. BIRTHPLACE (City and State or Foreign Country) WEST PLAINS, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME CLARK B. ROSSER	13b. MOTHER'S MAIDEN NAME CARRIE J. STEED	14. NAME OF HUSBAND OR WIFE ELLEN ROSSER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WWII YES	16. SOCIAL SECURITY NO. 499-07-6915	17. INFORMANT'S SIGNATURE OR NAME MRS. ELLEN ROSSER ADDRESS 5550 CENTRAL ST. KANSAS CITY, 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, 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) Strangulation		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident	21b. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) Home	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) TOWNSHIP JACKSON MO
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9-21-55 11 P.M.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR climb rung at closet and fall
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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 **11:00p. m.**, from the causes and on the date stated above.

23a. SIGNATURE Geo. C. Kealhofer (Degree or title)	23b. ADDRESS 6627 Pleasant St. Cum	23c. DATE SIGNED 9-25-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-24-55	24c. NAME OF CEMETERY OR CREMATORY Calvary Cem	24d. LOCATION (City, town, or county) (State) Kansas City MO
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DATE REC'D BY LOCAL REG. 9-24-55	REGISTRAR'S SIGNATURE Neal Marshall	25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE UND. CO. ADDRESS K.C. MO.
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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Adrian Jay Stitt*.....

Licensed Embalmer No. *495*

P. O. Address *N.C.,*.....

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.