FILED AUG 23 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 28,340

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3633

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: Gen'l Hosp. #1 — Length of stay in 1b: 8 YEARS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 8100 WORNALL ROAD — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Charles Middle: SUMNER Last: Ross

4. DATE OF DEATH: Month 7 Day 31 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARITAL STATUS: MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: NOV. 23. 1864

9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED-10 YRS. SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: RAPPH HOOP CHEMICAL COMPANY

11. BIRTHPLACE (City and state or country): QUINCY, ILLINOIS

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: SUMNER F. ROSS

13b. MOTHER'S MAIDEN NAME: ELIZA BRADFORD

14. NAME OF ~~HUSBAND OR~~ WIFE: MRS. LELIA FAY ROSS

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.: 493-12-3197

17. INFORMANT: MISS EDITH ROSS Address: MINNEAPOLIS, MINN.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 491X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 19, 1957, to July 31, 1957 and last saw him alive on July 31, 1957
Death occurred at 12:50 A.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): B. I. Burns, M.D.

22b. ADDRESS: 24th & Cherry

22c. DATE SIGNED: 7-31-57

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE: AUG-2-1957

23c. NAME OF ~~CEMETERY OR~~ CREMATORY: D.W. NEWCOMER'S SONS

23d. LOCATION (City, town, or county) (State): KANSAS CITY MISSOURI

24. FUNERAL DIRECTOR: D.W. NEWCOMER'S SONS ADDRESS: 1331 BRUSH CREEK KANSAS CITY MO.

25. DATE RECD. BY LOCAL REG.: 8-2-57

26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

B. I. Burns

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 Chester K Brown

Licensed Embalmer No. 4931

P. O. Address KC 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.