

pt. Health,
c. & Welfare
S. Public
alth Service

FILED DEC 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44568

STATE FILE NUMBER
5724

Registration District No. 189 Primary Registration District No. 1002

Registrar's No. 5724

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, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital 40 yrs.</u>		Length of stay in lb <u>40 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>3816 Marcell</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Frances Belle</u> Middle <u>Roach</u> Last <u>Roach</u>			4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-5-1869</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>
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>at home</u>	11. BIRTHPLACE (City and state or country) <u>Camden Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>Thomas O. Halloran</u>		13b. MOTHER'S MAIDEN NAME <u>Frances Murphy</u>		14. NAME OF HUSBAND OR WIFE <u>James L. Roach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>James L. Roach</u> Address <u>3816 Marcell K.C., Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforation of Cecum</u> DUE TO (b) <u>Peritonitis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) <u>Fracture of right femoral neck.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>690 3/20</u>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Fall on floor</u>			
20c. TIME OF INJURY Hour <u>11</u> Month <u>12</u> Day <u>26</u> Year <u>57</u> a.m. <u>-</u> p.m. <u>-</u>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>		20g. COUNTY <u>Jackson</u>		20h. STATE <u>MO</u>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Hugh H. Owens Coroner</u>			22b. ADDRESS <u>1034 North Blvd</u>		22c. DATE SIGNED <u>12-3-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-4-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Marcell Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
24. FUNERAL DIRECTOR <u>C. J. Blackman & Son Inc</u>		25. DATE RECD. BY LOCAL REG. <u>12-3-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Hugh H. Owens

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)
H.C. 778.



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 Bert B. Bennett

Licensed Embalmer No. 4656

P. O. Address K.C., 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.