

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034993

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Primary Registration District No. 1002 Registrar's No. 4430

STATE FILE NUMBER

9-2-60

Frederick D. Rose

Frederick B. Rose

DOCUMENT

Robert A. Moor, M.D. MEDICAL CERTIFICATION

BY AFFIDAVIT OF Informant

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, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 59 Years		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 210 West Dartmouth Road		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK D. B. ROSE				4. DATE OF DEATH Month Day Year AUGUST 26 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-6-1876	9. AGE (last birthday) 80 83	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY OVERHEAD DOOR CO.		11. BIRTHPLACE (City and state or country) ELMIRA, NEW YORK		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME JOHN W. ROSE			13b. MOTHER'S MAIDEN NAME MARY E. BLANCHARD		14. NAME OF HUSBAND OR WIFE Maude Rose		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 494 14 3758		17. INFORMANT Address MRS. MAUDE B. ROSE 210 WEST DARTMOUTH KANSAS CITY, MISSOURI			
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>Pneumonia</u> 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 <u>3 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Inter trochanteric fracture left femur complete</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Fell in home</u>				
20c. TIME OF INJURY Hour - p.m. Month, Day, Year <u>Aug. 18, 1960</u>	20d. INJURY OCCURRED WHILE AT WORK <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 COUNTY STATE <u>Kansas City Jackson Mo</u>		
21. I attended the deceased from <u>Aug. 19, 1960</u> to <u>Aug. 26, 1960</u> and last saw him alive on <u>Aug. 26, 1960</u> Death occurred at <u>10:40 p.</u> on the date stated above, and to the best of my knowledge from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Robert A. Moor, M.D.</u>				22b. ADDRESS <u>10609 14th St. K.C., Mo</u>		22c. DATE SIGNED <u>Aug 28, 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE <u>AUGUST 29, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>D. W. NEWCOMER'S SONS</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>		
24. FUNERAL DIRECTOR <u>D. W. NEWCOMER'S SONS KANSAS CITY, MO.</u>			25. DATE RECD. BY LOCAL REG. <u>8-29-60</u>		26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</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
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E. L. Gibson

Licensed Embalmer No. 4137
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.