

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

33463

1. PLACE OF DEATH
 County Jackson Registration District No. 1002 File No. _____
 Township Kearney Primary Registration District No. _____ Registered No. _____
 City Kansas City (No. 813 & 15-16) St. _____ Ward _____

2. FULL NAME Martha Stone
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe. 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 7-1904

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
14 4 3

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Packer
 (b) General nature of industry, business, or establishment in which employed (or employer) Lorrie-Wells Co
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) K.C. Mo.

10. NAME OF FATHER Harry J Stone

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

12. MAIDEN NAME OF MOTHER Rose Mahar

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill.

PARENTS

14. INFORMANT Mrs Rose Rew
 (Address) 813 & 15-16 St.

15. FILED Oct 13 18 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-10 1918

17. I HEREBY CERTIFY That I attended deceased from Oct 6 1918 to Oct 10 1918 that I last saw h. or alive on Oct. 10 1918 and that death occurred, on the date stated above, at 1213 R m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia

CONTRIBUTORY (SECONDARY) [Signature] (duration) yrs. mos. da.

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) [Signature] M. D.
Oct 11, 1918 (Address) 1044 Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Burieners Vault Oct-14 1918

20. UNDERTAKER ADDRESS
Burieners Sons K.C. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING

V. S. NO. 2.

