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

Do not use this space.

35473

File No. 3999

Registered No.

1. PLACE OF DEATH

County Jackson — Registration District No.

Township Kaw — Primary Registration District No.

City Kansas City Mo (No. St Vincent Hospital St. Ward)

2. FULL NAME Joan Edna Stanley

(a) Residence. No. 312 E. 69th St Terrace St. 8 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. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

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) Sept. 28, 1928

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Dean R. Stanley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Topeka
(STATE OR COUNTRY) Kansas

12. MAIDEN NAME OF MOTHER Marian G. Harrod

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) K. C.
(STATE OR COUNTRY) Mo

14. INFORMANT Dean R. Stanley
(Address) 312 E. 69th St Terrace

15. FILED 10/1, 1928 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 - 1 1928

17. I HEREBY CERTIFY, That I attended deceased from 9-28, 1928, to 10 1, 1928 that I last saw her alive on 9/30, 1928, and that death occurred, on the date stated above, at 3 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhage of brain sub dural

161B 161B

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Long delivery

Podalic Version (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Paralysis of left [illegible]

(Signed) [illegible], M. D

10/1, 1928 (Address) 835 Bialle

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Cremation

DATE OF BURIAL: 10/2/ 1928

20. UNDERTAKER: H. W. Gates

ADDRESS: K C Ks

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.

[illegible] WITH UNFADING INK—THIS IS A PERMANENT RECORD