

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

Do not use this space.

12957

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City (No. 24 50 Campbell)

Registration District No. 381
Primary Registration District No. 1000

File No. 1545
Registered No. 1545
St. 3 Ward

2. FULL NAME John Stodler

(a) Residence. No. 24 50 Campbell St. 3 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
About 65				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Germany

PARENTS	10. NAME OF FATHER <u>Not known</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>not known</u>
	12. MAIDEN NAME OF MOTHER <u>not known</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>not known</u>

14. INFORMANT Coroner's record
(Address) Kansas City, Mo

15. FILED 9-30 19 30 M. M. Corone REGISTRAR
Ass

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 28th 19 30

17. I HEREBY CERTIFY, that I attended deceased from Deputy Coroner, 19 30, to 19, 19 30, that I last saw h. alive on, 19 30, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
131
920
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic tubercular
myocarditis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 1290
IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) Stanley M. May, M. D.

428, 19 30 (Address) Deputy Coroner

*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 Maple Hill DATE OF BURIAL May 7 30

20. UNDERTAKER R. V. Lindsey & Sons, Inc ADDRESS City, Mo

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.

WHITE LABEL; WITH GRADING MARK THIS IS A PERMANENT RECORD

