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.

NOV 14 1934

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

Do not use this space.

1. PLACE OF DEATH

County Clay — Registration District No. 198 — File No. 35544

Township ~~Fishing River~~ — Primary Registration District No. 3011 — Registered No.

City Excelsior Springs, Mo. (No. Ex. Springs Sanitarium St. Ward)

24 2 4

2. FULL NAME Mrs. Grace A. Stoddard

(a) Residence, No. 534 Evanston St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 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): ~~married~~ widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: D. M. Stoddard

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Unknown 1873

7. AGE: YEARS 61 — MONTHS — DAYS — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Homework
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME: Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS): Ex. Springs Sanitarium - W. R. Graham, Ex. Springs, Mo.

18. BURIAL, CREMATION, OR REMOVAL: Mt. Washington
PLACE Kan. City, Mo. DATE 10-25- 1934

19. UNDERTAKER (ADDRESS): Rose & Henderson, 15 & Jackson, K.C. Mo.

20. FILED 10-24- 1934 Mrs Rea McCracken, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 10/23 - 1934

22. I HEREBY CERTIFY, That I attended deceased from Oct 12 - 1934 to Oct 23 1934
I last saw her alive on Oct 23 1934 Death is said to have occurred on the date stated above, at 9.45 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchial Pneumonia	Oct 18 1934
10 A 8 A / 07 A	

Other contributory causes of importance: neuritis — Do not Known

Name of operation ✓ Date of ✓
What test confirmed diagnosis? Clinical Course Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury ✓, 19
Where did injury occur? ✓ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury ✓
Nature of injury ✓

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) H J Clark, M. D.
(Address) 10/23/1934 Excelsior Springs Mo