

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

5305
Do not use this space.

REC'D MAR 9 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Raw Primary Registration District No. 190 Registered No. 504
 (c) City Kansas City (d) Street No. Research Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Steger Stout Independence, Mo. f. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Lena B. Stout
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-17-1869
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 70 0 10
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired
 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) Missouri
 FATHER 13. NAME Steger Stout
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia
 MOTHER 15. MAIDEN NAME Unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
 17. INFORMANT (ADDRESS) Robert Stout
Long Beach Calif
 18. BURIAL, CREMATION, OR REMOVAL PLACE Carrollton Mo DATE 1/29/39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Sting & McCune
Kansas City Mo
 20. FILED 276 19 39 M. M. Crowe
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-27-1939
 22. HEREBY CERTIFY, That I attended deceased from Dec 13, 1938, to 1/27, 1939
 I last saw him alive on 1/29, 1939. Death is said to have occurred on the date stated above, at 11:50 A
 The principal cause of death and related causes of importance were as follows:
Septicemia (Blood stream infection - Streptococcus)
 Date of onset ?
 Other contributory causes of importance: Ch. Valv. heart disease - Ch. Intestinal Neoplasm - Atherosclerosis
 Name of operation none Date of none
 What test confirmed diagnosis Ch. + Cult. 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 none, 1939
 Where did injury occur? none (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury none
 Nature of injury none
 Was disease or injury in any way related to occupation of deceased? no
 If so, specify none
 (Signed) Dr. E. J. Crowe M.
 (Address) 4800 E. 24th St. C. 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.

Dr. D. B. Edmonson
4800 S. 24th

Perm 5949

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.