

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.

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

24797  
Do not use this space.

REC'D AUG 7 1939

1. PLACE OF DEATH

(a) County JACKSON Registration District No. 399

(b) Township RAW Primary Registration District No. 1002 Registered No. 3010

(c) City KANSAS CITY (d) Street No. 2730 TRACY - 2ND FLOOR St.

(e) Length of residence in city or town where death occurred 47 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MRS. MARGARET GRACE STEVENSON

(a) Residence, No. 2730 TRACY 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 FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF SAMUEL M. STEVENSON

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCT-2-1853

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
	<u>85</u>	<u>9</u>	<u>23</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. AT HOME

9. Industry or business in which work was done, as saw mill, bank, etc.

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) SALEM NEW YORK

FATHER

13. NAME JOHN R. NELSON

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) NEW YORK

MOTHER

15. MAIDEN NAME MARtha JANE JOHNSON

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) NEW YORK

17. INFORMANT (NAME) (ADDRESS) MR. WILL D. STEVENSON 2730 TRACY AVENUE

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt WASHINGTON DATE JULY-27-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) D. W. NEWCOMER'S SONS 1401-13 BUSH CREEK BLVD

20. FILED July 26, 1939 M. M. Crown, ass't Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JULY-25-1939

22. I HEREBY CERTIFY, That I attended deceased from July 17<sup>th</sup> 1939 to July 25<sup>th</sup> 1939

I last saw her alive on July 24<sup>th</sup> 1939. Death is said to have occurred on the date stated above, at 11:50 A.M.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage  
Complete Transference  
Right side

Date of onset 7-17-39

Other contributory causes of importance:  
Arteriosclerosis  
Chronic myocarditis

Date 7-17-39

Name of operation None Date of None

What test confirmed diagnosis Clinical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? no Date of injury None, 19...  
Where did injury occur? None (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. None

Manner of injury None

Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify None

(Signed) H. Gentry M.D., M. D.  
(Address) 805 Elmwood av

805 E. University

**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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address D. C. Mo.

**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.**