

Registration District No. **198**

Primary Registration District No. **311**

1. PLACE OF DEATH:

(a) County **Jay** **NOV 7 1939 3**
(b) City or town **Excelsior Springs**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **4 Mr. South East Excelsior Springs**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) **1 day**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
(c) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **5445 Cherry St**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME **ROY ULYSSES STEVENS**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Hellie Stevens** 6. (c) Age of husband or wife if alive **Unknown** years
7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 44 hr. **15** min.

9. Birthplace **Sedalia, Mo.**
(City, town or county) (State or foreign country)

10. Usual occupation **Medical Doctor**

11. Industry or business **Medicine**

12. Name **Richard A. Stevens**

13. Birthplace **Wapona, Indiana**
(City, town or county) (State or foreign country)

14. Maiden name **A. Helen O. Cannon**

15. Birthplace **Pettis Co., Mo.**
(City, town or county) (State or foreign country)

16. (a) Informant's own signature **E. Nelson**

(b) Address **5631 Paseo Kansas City, Mo**

17. (a) **Removal** (b) Date thereof **10-30-39**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill**

18. (a) Signature of funeral director **Herbert Hoop**

(b) Address **Excelsior Springs, Mo**

19. (a) **10-31-39** (b) **Wm. W. McCreche**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **30** 19**39**
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **dead several hours 1200-14**
and that death occurred on the date and hour stated above.
that I last saw h. _____ alive on _____, 19____;

Immediate cause of death **suicide caused by taking monoxide gas from automobile**
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **164**

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **suicide**

(b) Date of occurrence **Oct 30 1939**

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **about 4 miles of Excelsior Springs**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Mrs. W. L. Wyman** (M. D. or other) _____

Address **Liberty City, Mo**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

RECEIVED
District Health Officer No. 8,
District File Number 11/2/39
Date Filed

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

Scott W. Hockensmith, Registered Apprentice No. 3597
working under my personal supervision.

Signed Scott W. Hockensmith

Licensed Embalmer No. 3597

P. O. Address Excelsior Springs, 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.