DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9970

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1404

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1½ hrs. (Specify whether

In this community 50 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 4409 E 10th (If rural, give location)

(e) If foreign born, how long in U. S. A.? No years.

3. (a) PRINT FULL NAME John Stanley 350

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 Widowed

6. (b) Name of husband or wife Edith Stanley

6. (c) Age of husband or wife if alive Dec. years

7. Birth date of deceased 11 (Month) 12 (Day) 1872 (Year)

8. AGE: Years 67 Months 3 Days 15 If less than one day hr. min.

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

10. Usual occupation Retired mechanic

11. Industry or business No

FATHER
12. Name John Stanley
13. Birthplace No record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No record
15. Birthplace No record (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John Stanley

(b) Address 4934 E 18th, Kansas City, Mo.

17. (a) Green Lawn Cem. (Burial, cremation, or removal) (b) Date thereof 3 (Month) 29 (Day) 40 (Year)

(c) Place: burial or cremation Green Lawn Cem. K. C. Mo.

18. (a) Signature of funeral director John P. Sheil

(b) Address 6606 Indep. Ave., K. C. Mo.

19. (a) Mch 29, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 27 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Acute pulmonary congestion

Due to (pending further investigation)

Other conditions (Include pregnancy within 3 months of death) 163

Major findings: Of operations Amperol Poisoning Hemorrhagic Gastritis

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

(b) Date of occurrence

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address K. C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

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.

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Rev. 5-17-39
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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.