

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

15068

MAY 17 1940 398  
Registration District No.

Primary Registration District No. 3019

State File No. \_\_\_\_\_  
Registrar's No. 111

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Independence  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1123 South Dodgeon  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day 4-9-40  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_  
that I last saw \_\_\_\_\_ on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Stella Sappenfield 151  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband James Byrd 6. (c) Age of husband 67 years  
7. Birth date of deceased 11 1 1875  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
64 5 8 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace No Record Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

MOTHER FATHER  
12. Name Joseph Walk  
13. Birthplace No Record Indiana  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Foot  
15. Birthplace No Record Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Stella Sappenfield  
(b) Address 1123 S. Dodgeon

17. (a) Burial (b) Date thereof 4-13-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound Grove

18. (a) Signature of funeral director Wm. H. Stahl  
(b) Address 815 W. Maple Ave

19. (a) April 13 - 40 (b) F. L. Cook  
(Date received local registrar) (Registrar's signature)

Duration \_\_\_\_\_  
3° degree burns of entire body  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 not know  
(b) Date of occurrence 4-8-40  
(c) Where did injury occur? Indep. Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, or industrial place, in public place?  
Found by a trespassing garage  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature Wm. H. Stahl (M. D. or other) \_\_\_\_\_  
Address 1123 S. Dodgeon Date signed \_\_\_\_\_

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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**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 \_\_\_\_\_

*Henry W. Stahl*

Licensed Embalmer No. 3181

P. O. Address Independence 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.**

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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18-0687  
Registrar's No. 111

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 398

Primary Registration District No. 3019

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Independence  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: 17 hospital or institution (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Ms Stella Sappenfield

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 64 Months 5 Days 8 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: month 4 day 9  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death 3d Degree Burns of entire body Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_

(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? Home in garage  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. SignaVictor B. Ryhlers M. D. or other) \_\_\_\_\_

Address Kansas City \_\_\_\_\_

SUPPLEMENTARY

