FILED JUN 17 1940

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17577

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 2104

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

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: St. Joseph's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Month (Specify whether years, months or days) In this community 1½ Months

2. USUAL RESIDENCE OF DECEASED:

(a) State: Iowa (b) County: Polk

(c) City or town: Grimes (If outside city or town limit write "RURAL")

(d) Street No.: R. F. D. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Mr. Harry Stone 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: Married

6. (b) Name of husband or wife: Mrs. Blanche Stone

6. (c) Age of husband or wife if alive: 45 years

7. Birth date of deceased: December (Month) 20 (Day) 1872 (Year)

8. AGE: Years 67 Months 5 Days 1 If less than one day ____ hr. ____ min.

9. Birthplace: Illinois (City, town, or county) (State or foreign country)

10. Usual occupation: Railroad Yardmaster--Retired

11. Industry or business: Rock Island-- 5 or 6 Yrs.

FATHER
12. Name: Samuel Stone
13. Birthplace: Tenn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Sarah Rankin
15. Birthplace: Tenn (City, town, or county) (State or foreign country)

16. (a) Informant: Elmer C. Stone
(b) Address: 4907 Wyoming

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 5-21-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Des Moines, Iowa

18. (a) Signature of funeral director: D. H. Newcomer's Sons
(b) Address: 1401 Brush Creek Blvd.

19. (a) May 21, 1940 (Date received local registrar) M. M. Browne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21st year 1940 hour 4 minute 15 A.M.

21. I hereby certify that I attended the deceased from Apr 16 1940 to May 21, 1940, to ____, 19__, that I last saw him alive on May 20, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
(a) Fibrinous pericarditis	3 wks
Septicemia (organism unknown)	3 wks
Due to: necrotizing cystitis	4 wks
para cystitis	4 wks
Due to:	
Other conditions (Include pregnancy within 3 months of death): 137	

Major findings: Of operations: Transurethral resection Hypertrophy of prostate

Of autopsy: see above

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): —

(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? ____ While at work? — (Specify type of place) (e) Means of injury: —

23. Signature: F. B. Wallace (M. D. ~~or other~~)

Address: 703 Lathrop Bldg. Date signed: 5/21/40

(Licensed Embalmer's Statement on Reverse Side)

12:30. 5-

OCT 14 1930

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 C. Hervey Quisenber

Licensed Embalmer No. 4070

P. O. Address K. 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.