

No. 2
4-13-40
5-17-39
I X23159

FILED AUG 14 1940
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3064

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
3216 Lockridge
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community 26 Years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 3216 Lockridge, K.C.Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME James Edgar Stevens, 315

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. Married
6. (b) Name of husband or wife Dr. Gertrude Stevens, 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased June 21st, 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 1 8
hr. min.

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

10. Usual occupation Osteopathic Physician

11. Industry or business _____

MOTHER FATHER { 12. Name Henry J. Stevens,
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Sweltzer,
(City, town, or county) (State or foreign country)
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Gertrude Stevens,
(b) Address 3216 Lockridge, K.C.Mo.

17. (a) Burial (b) Date thereof July 31-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Moriah

18. (a) Signature of funeral director Mrs. C.L. Forster,
(b) Address 918 Brooklyn Avenue, K.C.Mo.

19. (a) July 31, 1940 (b) M.M. Craue
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29th,
year 1940 hour _____ minute 7:45 A.M.

21. I hereby certify that I attended the deceased from May 1935 to July 29, 1940
and that death occurred on the date and hour stated above.

that I last saw him alive on July 28-11:30 P.M. 1940
Immediate cause of death Pericardial Cirulatory Failure
Cerebral Hemorrhage
Due to Arterial Sclerosis

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
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) _____
(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) (Specify type of means of injury)
23. Signature Arnold Green (Physician or other)
Address 11023 Waldheim Date signed 7-29-40

McLathum
N. 3604
11/11/11

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed W. H. Wise

Licensed Embalmer No. 2570

P. O. Address R. E. W.

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, fact should be so stated above.