

FILED MAY 12 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

13561

Registration District No.

399

Primary Registration District No.

1002

Registrar's No.

1622

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: K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 1 Mo. & 1 day
(Specify whether
In this community unk
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 7 East 7th St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Matthew Steilen

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

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 17 years
7. Birth date of deceased May 1879
(Month) (Day) (Year)

8. AGE: Years 62 Months 10 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

12. Name unknown
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Recd by Clerk

(b) Address K.C. Gen. Hosp

17. (a) Burial (b) Date thereof 4-24-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation maple St. W.C.H.

18. (a) Signature of funeral director Wm. M. Crowe

(b) Address City

19. (a) 4-24-42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12th
year 1942 hour 1 minute 20 P. M.

21. I hereby certify that I attended the deceased from 3-11-42 19____ to 4-12-42 19____
that I last saw h. im alive on 4-12-42 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic bronchopneumonia

Due to Bleeding peptic ulcer

Due to 17a

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

Major findings: Of operations _____

Of autopsy None

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) Means of injury 0

23. Signature Wm. R. Thow (M. D. or other) _____

Address Med. Dir. K. C. Gen. Hospital, K.C.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 *Wm. A. Lammey*

Licensed Embalmer No. *3089*

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, fact should be so stated above.