

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 11 1942

Registrar's No. 3272

Registration District No. 149

Primary Registration District No. 1002

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:
4401 Michigan /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether years, months or days) 1 Day - 5 days

3. (a) PRINT FULL NAME Mary Stephanz

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

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mathias Stephanz
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased December 26, 1877
(Month) (Day) (Year)

8. AGE: Years 64 Months 05 Days 34
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Own Home

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mary Stephanz
(b) Address 4401 Michigan

17. (a) Burial (b) Date thereof 9-3-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Calvary Cemetery

18. (a) Signature of funeral director John Crowe

(b) Address 340 North Sixth, K. C. Mo.

19. (a) 9-2-42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Wyandotte
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 430 North Fourth Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? About 50 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 30
year 1942 hour 4 minute - P.M.

21. I hereby certify that I attended the deceased from Jan 5 to Aug 30, 1942
that I last saw her alive on Aug 30, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Myocarditis Duration 1 year

Due to 938

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

Major findings:
Of operations _____
Of autopsy _____

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 3
23. Signature John Crowe (At D. or other) _____
Address 104 - James Ke Kous Date signed Sept 1 1942

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.

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 Amelia Stone

Licensed Embalmer No. 4113

P. O. Address 340 N. 6th St K-C

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.