

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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: 3910 Penn. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community 15 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. 3910 Penn. (If rural, give location) 0  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Jacob P. Stoll

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

4. Sex male 0 5. Color or race white 6. (a) Single, widowed, married, divorced, wid.  
6. (b) Name of husband or wife Nellie Jane Stoll 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased Feb. 24 1876  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
66 6 19 hr. min.

9. Birthplace Hickory Co. Mo. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Barber ret. 15 years

11. Industry or business

MOTHER FATHER { 12. Name Jacob P. Stoll  
13. Birthplace Alsace-Lorraine France 5  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary J. Lichty  
15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Jacob Stoll  
(b) Address 3916 Fisher

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-42  
(Month) (Day) (Year)  
(c) Place: burial or cremation Sycamore Cem. Garden City Mo.

18. (a) Signature of funeral director State Funeral Home  
(b) Address Kansas City

19. (a) 9-15-42 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13  
year 1942 hour 11 minute 17 M.

21. I hereby certify that I attended the deceased from Anna 19.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion  
Chronic myocardial infarction  
Due to 94a  
Due to.....  
Other conditions (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: Of operations.....  
Of autopsy Suicide  
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 OSBETH (Emb. or other).....  
Address 1000 Date signed 9/15/42

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

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.....

*W. J. Ward*

Licensed Embalmer No..... 3991

P. O. Address..... 309 E. 67th

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.