

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 30 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 232

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:
St. Mary's Hospital. 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo. (Specify whether
In this community 6 Yrs. (Specify whether
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. 1513 East 29th, Street.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Felix W. STOLP.

3. (b) If veteran, name war None
3. (c) Social Security 702-14-5936

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

6. (b) Name of husband or wife Elizabeth Stolp.
6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased February 23 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 10 21 hr. min.

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

10. Usual occupation Engineer
11. Industry or business Missouri Pacific R.R.

12. Name William Stolp.
13. Birthplace Germany.
(City, town, or county) (State or foreign country)
14. Maiden name Anna Hasse.
15. Birthplace Germany.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elizabeth Stolp.
(b) Address 1513 East 29th, Street.

17. (a) Burial (b) Date thereof 1/16/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery.

18. (a) Signature of funeral director Melody-McGilley.
(b) Address K. C. Mo.

19. (a) 1-15-43 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14th
year 1943 hour 1 minute 05 A.M.

21. I hereby certify that I attended the deceased from Aug 15
1942 to Jan 14, 1943
that I last saw him alive on Jan 13, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic glomerular nephritis with renal hypertension
Due to 131B

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy Chronic glomerular nephritis

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?

23. Signature J. E. Castle (M. D. or other)
Address 1802 Apple Bay Date signed 1-14-43

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

MOTHER FATHER

Duration

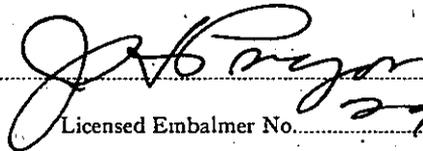
PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....



Licensed Embalmer No..... 2799

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.