

FILED OCT 13 1943

State File No. _____

4178

Registration District No. 949

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: St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 days
In this community 15 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Johnson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 5225 West 77th St. Terrace
(If rural, give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country X 2

3. (a) PRINT FULL NAME Miss Jacqueline Stiles,

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

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

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased May 14 1926
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
17 4 15 hr. min.

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

10. Usual occupation School Student

11. Industry or business X

MOTHER FATHER { 12. Name Frank C. Stiles, Sr.
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Eudora Thomas
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Frank C. Stiles, Sr.

(b) Address 5225 W. 77th St. Ter., Johnson Co., Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-43
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Temple

18. (a) Signature of funeral director Stino & McClure

(b) Address 3235 Gillham Plaza, Kansas City, Mo.

19. (a) 10-1-43 (b) N. C. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 29th
year 1943 hour 8:55 minute P. M.

21. I hereby certify that I attended the deceased from Sept 25, 1943, to Sept 28, 1943
that I last saw or alive on Sept. 28, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor, third ventricle probably malignant

Duration 4 mos.

Due to STZ
Due to 64

Other conditions Encephalitis, history not determined
(Include pregnancy within 3 months of death)

Major findings: Third ventricle tumor, unoperated - diffuse encephalomalacia
Of autopsy none

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)
(e) Means of injury _____

23. Signature Frank C. Stiles, Sr. (M. D. or other) MS
Address 1630 Professional Bldg Date signed 10-1-43

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

Drs. Oglevie, Elliott and
Teacher

VS. 1643
after 2 P.M.

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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

J. Clair Shepherd

Licensed Embalmer No. *4127*

P. O. Address *H. L. No.*

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.