

FILED JAN 5 1944  
Registration District No. **149**

Primary Registration District No. **1002**

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

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. MARY'S HOSPITAL**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 MONTH**  
(Specify whether years, months or days)

In this community **7 YEARS**

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. **3424 GILLHAM ROAD**  
(If rural, give location)

(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **MRS. GRACE ADER STITT**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **41626-7711**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC** day **22<sup>ND</sup>**  
year **1943** hour **11** minute **35 A.M.**

21. I hereby certify that I attended the deceased from **2/2/42**  
\_\_\_\_\_ 19\_\_\_\_ to **12/22** 19\_\_\_\_  
that I last saw him alive on **12/22** 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **MR. JACKSON O. STITT**

6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased **AUGUST-23-1881**  
(Month) (Day) (Year)

Immediate cause of death

Due to **Chronic arterial sclerosis heart disease**

Due to **Cholecystitis & stones in gallbladder**

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy **as above**

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day

**62** **3** **30** hr. \_\_\_\_\_ min.

9. Birthplace **Parramatta, N.S.W.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Seamstress**

11. Industry or business **Rothchilds (Retired)**

12. Name **Wm A Ader**

13. Birthplace **Mercer Co, Mo**  
(City, town, or county) (State or foreign country)

14. Maiden name **Mariab Pickels**

15. Birthplace **Mercer Co, Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **MR. JACKSON O. STITT**

(b) Address **3424 GILLHAM ROAD**

17. (a) **BURIAL** (b) Date thereof **DEC-24-1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MEMORIAL PARK CEM.**

18. (a) Signature of funeral director **D. W. Newcomer, Inc**

(b) Address **1401 BRUSH GREEN BLYD.**

19. (a) **12-23-43** (b) **D. E. Brown**  
(Date received local registrar) (Registrar's signature)

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 **James D. Hov** (M. D. or other) \_\_\_\_\_  
Address **844 Park Street** Date signed **1/22/44**

John B. B. B.

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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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K C M

**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.**