

No. 2
-5-43
-17-39
X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20897

State File No.

FILED JUN 29 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2507

1. PLACE OF DEATH

(a) County Jackson
(b) City or town K.C.
(c) Name of hospital or institution:
709 Washington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
In this community 30 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48
(c) City or town K.C. 3
(d) Street No. 709 Washington 8
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME FRANK E STODDARD

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

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced unknown
6. (b) Name of husband or wife.
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 22 1871
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 19
If less than one day hr. min.

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

10. Usual occupation Real Estate

11. Industry or business

12. Name Henry Stoddard

13. Birthplace Michigan
(City, town, or county) (State or foreign country)

14. Maiden name Dottie Elliott

15. Birthplace Michigan
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. L. J. Eckert

(b) Address Durant Iowa

17. (a) Burial (b) Date thereof 6/13/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Leary Cem. K.C.

18. (a) Signature of funeral director Sebetsch
(b) Address 901 E 5th

19. (a) 6-13-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4
year 1944 hour minute M.
21. I hereby certify that I attended the deceased from
19 to 19
That I last saw h. Deputy Coroner
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart
Due to Disease.
Due to 93d
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy Inspection & history
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? N.Y.

While at work (Specify type of place) (c) Means of injury
23. Signature A. E. Washer (M. D. or other)
Address 2311 1/2 Date 6/10/44

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

MOTHER FATHER

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 _____

Ray E. Snow

Licensed Embalmer No. _____

2560

P. O. Address _____

156 Mo.

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.