

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Rural Prairie
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Jackson County Emg. Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 da. (Specify whether years, months or days)
 In this community 57 years.

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Independence
(If outside city or town limits, write "RURAL")
 (d) Street No. 11226 E. 20th
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME James Stimson
 3. (b) If veteran, name war no
 3. (c) Social Security No. no

4. Sex Male 5. Color or race wh.
 6. (a) Single, widowed, married, divorced 2
 6. (b) Name of husband or wife Minnie Stimson
 6. (c) Age of husband or wife if alive ? years
 7. Birth date of deceased December 5th 1857
(Month) (Day) (Year)

8. AGE: Years 87 Months 11 Days 8
 If less than one day hr. min.

9. Birthplace England
(City, town, or county) (State or foreign country)
 10. Usual occupation Farmer

11. Industry or business _____
 12. Name Thomas Stimson
 13. Birthplace England
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Harry Stimson (son)
 (b) Address 11226 E. 20
 17. (a) Burial (b) Date thereof Nov. 29 44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Forest Hill Cem. K.C. Mo
 18. (a) Signature of funeral director Edm. Collier
 (b) Address 11.03 W. Main St. Indep. Mo
 19. (a) Nov 28-44 (b) F.M. Schickel & Co.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 27th
 year 1944 hour 5 minute 20 A.M.
 21. I hereby certify that I attended the deceased from November 24th 1944, to November 26 44
 that I last saw him alive on Nov. 26-1944 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Fatal burn
& secondary toxicity
 Duration _____

Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy _____
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 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)
 Means of injury _____
 23. Signature Harry B. Reis, M.D.
 Address St. Lukes Hosp. K.C. Mo. Date signed 11-27-44

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

George M. Callier

Licensed Embalmer No. *3839*

P. O. Address

Indep. 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. JAN
Registrar's No. 150

Registration District No. 150 Primary Registration District No. 5572

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Jackson
(c) Name of hospital or institution:
Funeral Parlor
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) City or town _____ (If outside city or town limits, write "RURAL")
(b) County _____
(c) Street No. _____ (If rural, give location)
(d) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Stinson
3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 5 1905
(Month) (Day) (Year)
8. AGE: Years 37 Months 21 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 26
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Nov 26
1944 from 27 1944
that I last saw him Nov 27 arrive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death 2nd and 3rd degree burns of face extremities and right half of thoracic region followed by secondary toxemia from burn area producing death

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
ADDITIONAL
SUPPLEMENTARY
CORROBORATION
NECESSARY

Duration _____
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) Accident

(b) Date of occurrence Nov 25, 1944

(c) Where did injury occur? Residence (Independent)
(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 Burn

23. Signature Dr. Harry B. Keis (M. D. or other)

Address Naval Hospital, California Date signed _____

SUPPLEMENTARY

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

41358