

S. No. 2
OM-5-43
v. 5-17-39
I X36671

24194 ✓

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 163

FILED JUL 21 1945

Registration District No. 746

Primary Registration District No. 5568

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Blue Twp Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
307 North Home Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson UR

(c) City or town Blue Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 307 North Home Ave.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME PAUL STEIN

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Emilie Stein

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased April 6, 1870
(Month) (Day) (Year)

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

75	2	1	hr. min.
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9. Birthplace Hanover, Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Cobler

11. Industry or business Shoe Repair

12. Name No Data

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

14. Maiden name No Data

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

16. (a) Informant Mrs. Emilie Stein

(b) Address Kansas City, Missouri

17. (a) Burial (b) Date thereof 6/9/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery

18. (a) Signature of funeral director Wesley Cannon
(b) Address Independence, Missouri

19. (a) June 9, (b) 45
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7,
year 1945 hour 8 minute A M.

21. I hereby certify that I attended the deceased from 4-1-45
to 6-2-45, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 3 wks

Due to senility

Due to _____

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

Major findings:
Of operations _____

Of autopsy 830

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? _____

18. (a) Signature of funeral director Wesley Cannon While at work (c) Means of injury _____

(b) Address Independence, Missouri

19. (a) June 9, (b) 45
(Date received local registrar) (Registrar's signature)

Signature Ralph Barker Date signed 6-9-45
Address 307 North Home Ave. K.C.

(Licensed Embalmer's Statement on Reverse Side)

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.....

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.