

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 260

Primary Registration District No. 6225

Registrar's No. 110

1. PLACE OF DEATH:

(a) County Verdon

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

(c) Name of hospital or institution State Hosp # 3  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 yrs 10 months  
(Specify whether years, months or days)

In this community same  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Frank Stogsdill

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Myrtle Stogsdill

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased Dec 9, 1892  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>52</u>	<u>7</u>	<u>20</u>	hr. _____ min. _____

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

10. Usual occupation Farm

11. Industry or business \_\_\_\_\_

12. Name Jane Stogsdill

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

14. Maiden name Amanda Nellie

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

16. (a) Informant Deep Reed

(b) Address \_\_\_\_\_

17. (a) Removal  
(Burial, cremation, or removal)

(b) Date thereof 7-25-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Mo

18. (a) Signature of funeral director Mrs E L Foster

(b) Address 918 Brooklyn St S, Mo

19. (a) 7-25-45  
(Date received local registrar)

(b) Harold B. DeWick  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 2811 Holmes St  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24  
year 1945 hour 11 minute 00 M.

21. I hereby certify that I attended the deceased from Sept 25, 1940, to July 24, 1945

that I last saw he alive on July 24, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Coronary Occlusion

Due to Syphilis

Due to \_\_\_\_\_

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: None

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_

(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 W J Cremer (M. D. or other) \_\_\_\_\_

Address Merada Date signed 7/24/45

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

RECEIVED

District Health Officer No. 7,

District File Number 7-43-7-6-6

Date Filed 8-9-45

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 Ortland Minor

Licensed Embalmer No. 3414

P. O. Address 915 Brooklyn

R.C. 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.