V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26612

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3534

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: 5826 FOREST AVENUE 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---- (Specify whether
In this community 32 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 4

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

(d) Street No. 3855 EAST 62ND STREET
(If rural, give location)

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

If yes, name country ----

3. (a) PRINT FULL NAME MR JAMES W. STORMS, SR

3. (b) If veteran, name war NO

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 MRS. BLANCHE B. STORMS

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased JUNE (Month) 14 (Day) 1868 (Year)

8. AGE: Years 77 Months 2 Days 8 If less than one day ___ hr. ___ min.

9. Birthplace CASS COUNTY (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation RETIRED PRINCIPAL JUNIOR HIGH SCHOOL

11. Industry or business BOARD OF EDUCATION

FATHER
12. Name JOHN STORMS
13. Birthplace CASS COUNTY (City, town, or county) MISSOURI (State or foreign country)

MOTHER
14. Maiden name MAGGIE BRISCOE
15. Birthplace CASS COUNTY (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant MRS. BLANCHE B. STORMS

(b) Address 3855 EAST 62ND STREET

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG-24-1945 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ FOREST HILL CEMETERY

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 8-23-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 22ND year 1945 hour 10 minute 05 A.M.

21. I hereby certify that I attended the deceased from Deputy Corner, 19__; that I last saw h__ alive on ____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Senility & arteriosclerosis

Due to

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

Major findings:
Of operations no op. 83a

Of autopsy no 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) no accident

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Kans Conn Date signed 8/22/45

(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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K 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.