

FILED APR 10 1946

Registration District No. **149**

Primary Registration District No. **1002**

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:
RESEARCH HOSPITAL
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3-DAYS**
(Specify whether years, months or days)
 In this community **12 YEARS**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **JACKSON**
 (c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3130 - OLIVE STREET**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **---**

3. (a) PRINT FULL NAME **MRS. RUTH FRANCES STADALMAN**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **MARCH** day **31** 19**46**
 year **1946** hour **5** minute **45 P.M.**
 21. I hereby certify that I attended the deceased from **3-28-46**
 _____, 19____, to **3-31-** 19**46**
 that I last saw her alive on **3-31-** 19**46**
 and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE**
 6. (a) Single, widowed, married, divorced **MARRIED**
 6. (b) Name of husband or wife **MR. R. M. STADALMAN**
 6. (c) Age of husband or wife if alive **35** years
 7. Birth date of deceased **MAY-22-1918**
(Month) (Day) (Year)

Immediate cause of death _____
 Due to **Ruptured appendix**
 Due to **6 mo pregnancy (no delivery)**
 Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years **27** Months **10** Days **9**
 If less than one day _____ hr. _____ min.

9. Birthplace **OMAHA NEBRASKA**
(City, town, or county) (State or foreign country)
10. Usual occupation **HOUSEWIFE**

Major findings:
 Of operations _____
 Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____
12. Name **LEONARD EVERETT**
13. Birthplace **SANDUSKY OHIO**
(City, town, or county) (State or foreign country)
14. Maiden name **DOWNNEY FRANK**
15. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **MR. R. M. STADALMAN**
(b) Address **3130 - OLIVE STREET**
17. (a) BURIAL (b) Date thereof **APR-2-1946**
(Burial, cremation, or removal) (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) 4-2-46 (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

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 **E. E. ...** (M. D. or ...) _____
Address **3850 ...** Date signed **3-31-46**

JUL 12 1946

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.....

Paul Papp

Licensed Embalmer No.....

3458

P. O. Address.....

N.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.