

No. 2
4-2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
STATE BOARD OF HEALTH OF MISSOURI
FILED APR 22 1946
STANDARD CERTIFICATE OF DEATH

State File No. **13384**
Registrar's No. **1724**

Registration District No. **149** Primary Registration District No. **1002**

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: **K.C. TB Hosp. O**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12 DAYS**
(Specify whether years, months or days)
In this community **6 YRS.**

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. **2443 Forest Ave**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **SAM STEPHENSON**
3. (b) If veteran, name war **NO** 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **APRIL** day **7**
year **1946** hour **9:50** minute **A.M.**
21. I hereby certify that I attended the deceased from **3-26-46**
to **4-7-46**
that I last saw him alive on **4-7-46**
and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **MARRIED**
7. Birth date of deceased: **JAN 12 1894**
(Month) (Day) (Year)

Immediate cause of death: **PULMONARY TUBERCULOSIS**
Duration **4 MO**

8. AGE: Years **52** Months **28** Days **25** If less than one day hr. min.

Due to _____
Due to _____

9. Birthplace: **CUBA**
(City, town, or county) (State or foreign country)

Other conditions: **Myocarditis & decompensation**
(Include pregnancy within 7 months of death)

10. Usual occupation: **CLEANER & PRESSER**

Major findings: **138**
Of operations _____
Of autopsy _____

11. Industry or business _____

12. Name **WEBBEECES, JACK**

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

14. Maiden name **"UNKNOWN", ANICE**

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

16. (a) Informant **K.C. TB Hosp.**
(b) Address **KANSAS CITY, MO.**

17. (a) **Burial** (b) Date thereof **4-11-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Highland Cem**

18. (a) Signature of funeral director **G. Steinhilber**
(b) Address **1212 W. 8th St. Kansas City, Mo.**

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 **A. L. Coffey** (M. D. or other) **md.**
Address **Kansas City, Mo.** Date signed _____

19. (a) **4-11-46** (b) **Sheraldine Holman**
(Date received local registrar) (Registrar's signature)

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.....

E. Sterling Hills

Licensed Embalmer No.....

3178

P. O. Address.....

1212 Pine St. N.C.

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.