

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:
General Hospital No. 10
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **14 days**
(Specify whether
 In this community **47 yrs**
years, months or days)

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. **3947 Norton**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Addison Stone**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **702-10-2152**
 4. Sex **Male** 5. Color or race **white**
 6. (a) Single, married, divorced, widowed **Married**
 6. (b) Name of husband or wife **Warne Stone**
 6. (c) Age of husband or wife if alive **57** years
 7. Birth date of deceased **Oct-16-1886**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **May** day **11**
 year **1947** hour **1** minute **40 P.M.**
 21. I hereby certify that I attended the deceased from
April 27 19 **47** to **May 11** 19 **47**
 that I last saw him alive on **May 11** 19 **47**
 and that death occurred on the date and hour stated above.
 Immediate cause of death: **Myocardial infarction**
 Duration _____

8. AGE: Years **60** Months **9** Days **1**
 If less than one day hr. _____ min. _____
 9. Birthplace **San Diego** **California**
(City, town, or county) (State or foreign country)

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

10. Usual occupation **Switchman**
 11. Industry or business **M. K. & T. Railroad**
 12. Name **Addison B. Stone**
 13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
 14. Maiden name **Mary Robinson**
 15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

Major findings: _____
 Of operations _____
 Of autopsy **None**
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Warne Stone**
 (b) Address **3947 Norton**
 17. (a) **Burial** (b) Date thereof **5-15-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Mt. Washington**
 18. (a) Signature of funeral director **W. C. L. Foster**
 (b) Address **918 Brooklyn**
 19. (a) **5-13-47** (b) **Almaidine 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 **W. C. L. Foster** (M. D. or other) **MD**
 Address **Med. Dir. Gen'l Hosp.** Date signed **5-12-47**

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

MOTHER FATHER

Dr. Schumler

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 *Dean Owens*

Licensed Embalmer No. *4280*

P. O. Address. *918 Brooklyn
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.