

S. No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16532
Registrar's No. 2020

FILED MAY 22 1948

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15½ hrs. (Specify whether
In this community Unknown
years, months or days)

3. (a) PRINT FULL NAME George J. Stackpole
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 Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 14 1884
(Month) (Day) (Year)

8. AGE: Years 63 Months 9 Days X13 If less than one day _____ hr. _____ min.

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

10. Usual occupation Not known

11. Industry or business _____

MOTHER FATHER
12. Name Not known
13. Birthplace Not known
(City, town, or county) (State or foreign country)
14. Maiden name Not known
15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address General Hospital No. 1

17. (a) Anatomical (b) Date thereof 5-11-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Western Dental College

18. (a) Signature of funeral director Weilert Funeral Home

(b) Address Kansas City, Missouri

19. (a) 5-11-48 (b) Theraldine Holmes
(Date received local registrar) (Registrar's signature)

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. 513 Main (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April 27
year 1948 hour 10 minute 7 A. M.

21. I hereby certify that I attended the deceased from April 26, 1948, to April 27, 1948
that I last saw him alive on April 27, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation Duration _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 95°
Of operations _____
Of autopsy None 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 Wm. W. Hart (M. D. or other) W. W. Hart
Address Med. Dir. Gen'l Hosp. Date signed 5-3-48

Dr. Cady

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 *Blaine E. Weibert*

Licensed Embalmer No. *4075*

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.