

FILED OCT 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34002

State File No.

4254

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4254</u>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>1 1/2 YRS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		63	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4332 FLORA AVENUE</u>				d. STREET ADDRESS (If rural, give location) <u>4332 FLORA AVENUE</u>			
3. NAME OF DECEASED a. (First) <u>MRS. AMELIA PAULINE</u>			b. (Middle) _____			c. (Last) <u>STALLBORIES</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 2-1949</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>Nov. 15-1875</u>		9. AGE (In years last birthday) <u>73 YRS</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 12 HRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PEKIN, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOHN STANGE</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET</u>		14. NAME OF HUSBAND OR WIFE <u>William Henry Stallbories</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>H.M. STALLBORIES, DALLAS, TEXAS</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerotic Heart Disease 10 yrs</u> DUE TO (c) <u>Senility</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>4224</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Jan 16, 1949</u> to <u>Oct 2, 1949</u> , that I last saw the deceased alive on <u>Oct 2, 1949</u> , and that death occurred at <u>6:25 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>G. R. Maser</u> (Degree or title) _____				23b. ADDRESS <u>Missouri Kans</u>		23c. DATE SIGNED <u>10/4/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>OCT. 4, 1949</u>		24c. NAME OF CEMETERY OR CREMATORIUM <u>MEMORIAL PARK CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO</u>	
DATE REC'D BY LOCAL REG. <u>10-4-49</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D. H. Newcomer's Sons, Kansas City, Mo</u>			

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

Mission, Kansas - 5832 Quaker Street

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed

Doyle L. Daniel

Licensed Embalmer No. 4702

P. O. Address KCMo.

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.