

FILED MAR 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4952
State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 635

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
c. LENGTH OF STAY (in this place) 40 YRS.		d. STREET ADDRESS (If rural, give location) 315 GLADSTONE	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) ABBA	b. (Middle) STONE	c. (Last) MORSE	4. DATE OF DEATH (Month) (Day) (Year) FEB 8 1950
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MARCH 17, 1896	9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) INDIANA	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME JOHN S. -STONE	13b. MOTHER'S MAIDEN NAME Yengling	14. NAME OF HUSBAND OR WIFE RALPH MORSE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME RALPH MORSE	ADDRESS 315 GLADSTONE
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Septicemic Peritonitis		INTERVAL BETWEEN ONSET AND DEATH 10 days
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple Hemorrhages			3 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 1-28-1950 to 2-8-1950, that I last saw the deceased alive on 2-7-1950, and that death occurred at 6:30 AM., from the causes and on the date stated above.

23a. SIGNATURE W. M. Ketcham (Degree or title)	23b. ADDRESS KC Mo	23c. DATE SIGNED 2-8-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 2/10/50	24c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON	24d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
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DATE REC'D BY LOCAL REG. 2-10-50	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE	ADDRESS KANSAS CITY, MISSOURI
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Handwritten scribbles at the top left of the page.

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 _____

[Handwritten Signature]

Licensed Embalmer No. _____

1418

P. O. Address _____

A. 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.