

FILED SEP 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26295

BIRTH NO. _____ REG. DIST. NO. 3 PRIMARY REG. DIST. NO. 4095 Registrar's No. 130

| | | | | | |
|---|--|--|---|--|------|
| 1. PLACE OF DEATH a. COUNTY Cass | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY CASS | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Drexel | | c. LENGTH OF STAY (In this place) Life | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Drexel | | 0190 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | | d. STREET ADDRESS (If rural, give location) 0 | | |

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|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) - c. (Last) Stoker | | | 4. DATE OF DEATH (Month) (Day) (Year) Aug. 25, 1950 | | |
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|--|----------------------------------|--|---|--|--|---------------------------|---|--------------------------|-------------------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Feb. 25, 1873 | | 9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 1 MIN. Hours | IF UNDER 1 MIN. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house-wife | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Miami Co. Kan. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |

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|---|--|--|--|--|--|
| 13a. FATHER'S NAME Peter F. Jackson | | 13b. MOTHER'S MAIDEN NAME Minerva Hill | | 14. NAME OF HUSBAND OR WIFE deceased | |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lawton Stoker LaCygne, Kansas | | | |
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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. | MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Rt. Ovary. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH not known |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility Senile Arterio Sclerosis | 175X | | | | |

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|------------------------------------|--|--|--|--|---|
| 19a. DATE OF OPERATION - | 19b. MAJOR FINDINGS OF OPERATION - | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) - | |
| 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? - | |

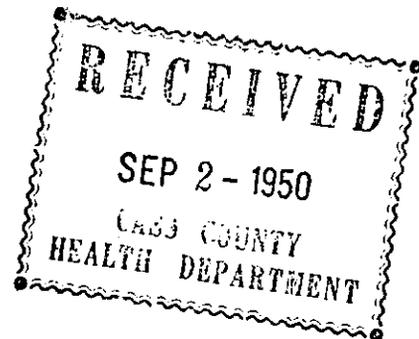
22. I hereby certify that I attended the deceased from **Aug. 21, 1950**, to **8-25-50, 1950**, that I last saw the deceased alive on **8-24-50, 19**, and that death occurred at **7:30am**, from the causes and on the date stated above.

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| 23a. SIGNATURE Basil C. Hartwell M.D. | | 23b. ADDRESS Drexel Mo. | 23c. DATE SIGNED 8-26-50 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | 24b. DATE 8-27-50 | 24c. NAME OF CEMETERY OR CREMATORY Rockville | 24d. LOCATION (City, town, or county) (State) Miami Co. Kansas |
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|--|--|----|--|
| DATE REC'D BY LOCAL REG. 8-27-50 | REGISTRAR'S SIGNATURE Laura J. Jones | 51 | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mangold Funeral Service LaCygne Kan |
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WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

L. A. Mangold

Signed.....

Student Embalmer

Licensed Embalmer No. 3610

P. O. Address Amsterdam, 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.