

FILED DEC 9 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 37267

4930

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4930</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) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>50 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>2223 Denver Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>General Hospital No. 1</u>				3. NAME OF DECEASED a. (First) <u>Maude</u> (Type or Print) b. (Middle) <u>L.</u> c. (Last) <u>Storms</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 7.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11 21 50</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>Nov. 30, 1874</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 6 WKS. Hours Min. <u>75</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>John R. Allsworth</u>			
13b. MOTHER'S MAIDEN NAME <u>Catherine Bierer</u>		14. NAME OF HUSBAND OR WIFE <u>Robert E. Storms, dec.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Maude Frogue, 7315 Walrond, K. C. Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary sclerosis with diffuse myocardial fibrosis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS: <u>Fracture of femur</u> CONDITIONS contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH  <u>42 21</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>At home</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Kansas City, Jackson, Missouri</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10 6 50</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fall</u>			
22. I hereby certify that I attended the deceased from <u>Oct. 6</u> , 19 <u>50</u> , to <u>Nov. 21</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Nov. 21</u> , 19 <u>50</u> , and that death occurred at <u>7:45A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>B.I. Burds</u> (Name or title) <u>MD</u>				23b. ADDRESS <u>24th &amp; Cherry</u>		23c. DATE SIGNED <u>11-21-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>11/21/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>-</u>		24d. LOCATION (City, town, or county) (State) <u>Raymore, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>11-22-50</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>STINE &amp; McCLURE, Kansas City, Missouri</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

*Dr. Cooper*

revoked

**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 *J. G. Pleas*

Signed.....  
Student Embalmer

Licensed Embalmer No. *1415*

P. O. Address *Id. O. My*

**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.