

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24959

FILED AUG 2 1957

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 314

300
-57

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, give TOWNSHIP only) OR Independence		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City 300 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1400 No. River		Length of stay in lb 2 days	d. STREET ADDRESS 579 Evanston (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First FRANCES Middle ELIZABETH Last STONEKING			4. DATE OF DEATH Month July Day 21 Year 1957		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1880	9. AGE (In years last birthday) 76	10. FUNDERS YEAR Months Days	11. IF UNDER 24 HRS. Hours 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 Home	11. BIRTHPLACE (City and state or country) Harrisonville, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Henry Hendrix	13b. MOTHER'S MAIDEN NAME Anna Vaughn	14. NAME OF HUSBAND OR WIFE James B. Stoneking
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give dates of service) none	16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Fred Ross, 571 Evanston, Kansas City 21	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Vascular Hemorrhage		3 months
	DUE TO (c) Generalized Arteriosclerosis		5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from July 1950 to July 57 and last saw her/him alive on July 21 1957 Death occurred at 10:55 A. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John W. Smith M.D. (Degree of title)	22b. ADDRESS 10229 Indus Ave / KCP Mo	22c. DATE SIGNED 7-23-57
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23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial-Removal	July 23, 1957	Sunset Hills Cemetery	Warrensburg, Missouri

24. FUNERAL DIRECTOR George C. Carson, Independence, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 7-23-57	26. REGISTRAR'S SIGNATURE [Signature]
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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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
Signature of Student Embalmer

Signed *H. Gibson*
Licensed Embalmer No. *4871*
P. O. Address *Indep. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.