

FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36165
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4498

S. 300
1-57

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, give TOWNSHIP only) <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u> Length of stay in lb <u>37 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>2418 Cypress</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First <u>Nellie</u> Middle <u>May</u> Last <u>Stevens</u>			DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March-29-1883</u>
9. AGE (In years, last birthday) <u>74</u>		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Lyndon Vermont</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>James B. Paul</u>	
13b. MOTHER'S MAIDEN NAME <u>Jennie Gall</u>		14. NAME OF HUSBAND OR WIFE <u>George S. Stevens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[Blank]</u>	17. INFORMANT <u>Geo. S. Stevens</u> Address <u>2418 Cypress N. C. Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>74 yr. Chronic Cardiac Vascular disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Parkinsons Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>443x</u>
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.)	
20c. TIME OF INJURY. Hour <u>-</u> a.m. <u>-</u> p.m. <u>-</u>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK 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	
21. I attended the deceased from <u>July 56-57</u> , to <u>9/26/57</u> and last saw her alive on <u>9-26-57</u> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Paul A. Klenberger M.D.</u>		22b. ADDRESS <u>5246 St. John</u>	22c. DATE SIGNED <u>9/27/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept-29-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
24. FUNERAL DIRECTOR <u>C. H. Blackman Son Inc.</u> ADDRESS <u>K.C. Mo.</u>		25. DATE RECD. BY LOCAL REP. <u>9-27-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Paul A. Klenberger M.D. ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)



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 *W. C. Quinn*

Licensed Embalmer No. *4879*

P. O. Address *W. C. Quinn*

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.