

Health,
& Welfare
S. Public
th Service

FILED DEC 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44617
STATE FILE NUMBER
5681

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

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Chillicothe	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If outside, give location) 1309 W. 3rd	
Length of stay in lb 1 Day		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Robert Middle L. Last Stoner			4. DATE OF DEATH: Nov. 29, 1957 Month Day Year		
--	--	--	--	--	--

5. SEX Male	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 Dec. 29, 1899	9. AGE (In years last birthday) 58 57	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	---------------------------------------	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (City and state or country) Kansas City, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
---	--	--	---

13a. FATHER'S NAME Charles Stoner	13b. MOTHER'S MAIDEN NAME Martha Shipman	14. NAME OF HUSBAND OR WIFE Flossie M. Stoner
---	--	---

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. 486-12-7288	17. INFORMANT Marguerite Prater	Address Merriam, Kansas
--	---	---	-----------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung primary		INTERVAL BETWEEN ONSET AND DEATH 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	162x
	DUE TO (c) _____	
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):
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month _____ Day _____ Year _____
---	----------------------------------

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 _____
--	--	--

21. I attended the deceased from 11/18/57 to 11/29/57 and last saw him alive on 11/29/57.
Death occurred at 1:00 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Arthur B. Rhoades MD	22b. ADDRESS 1104 Professional Bldg X 2	22c. DATE SIGNED 11/29/57
---	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (specify) Burial	23b. DATE 11-29-57	23c. NAME OF CEMETERY OR CREMATORY Chillicothe Cemetery	23d. LOCATION (City, town, or county) (State) Chillicothe, Missouri
--	------------------------------	---	---

24. FUNERAL DIRECTOR Stine & McClure	ADDRESS Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 11-30-57	26. REGISTRAR'S SIGNATURE Neva Marshall
--	------------------------------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

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.
Arthur B. Rhoades

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

DEC 18 1957

KP
2

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 *Eugene A. Johnson*

Licensed Embalmer No. *4633*

P. O. Address *Johnson City, N.C.*

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.