

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-029277

STATE FILE NUMBER  
3978

FILED SEP 5 1958

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

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If in hospital or institution) <b>3240 Norledge</b>		Length of stay in 1b <b>91 Yrs</b>	d. STREET ADDRESS (If outside, give location) <b>2637 Cleveland</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>James William Stovall</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>16</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Jan 1867</b>		9. AGE (In years last birthday) <b>91</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Cutter</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>John Stovall</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Wilcoxain</b>	
14. NAME OF HUSBAND OR WIFE <b>*****</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>486-09-7954</b>	
17. INFORMANT <b>Mrs Henry Vesey (niece) Delhi, Iowa.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>	
Conditions, if any, which gave rise to, above cause (a), stating the underlying cause last.		DUE TO (b) <b>Coronary Artery Arteriosclerosis</b>		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 _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <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 <b>Kansas City Jackson Mo</b>			
21. I attended the deceased from <b>Jan 58</b> to <b>Aug 1, 58</b> and last saw him alive on <b>Aug 1, 1958</b> . Death occurred at <b>10:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>K. L. Shireman MD</b>			22b. ADDRESS <b>4606 St John Rd</b>		22c. DATE SIGNED <b>8-16-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug 18 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brookings</b>		23d. LOCATION (City, town, or county) (State) <b>Raytown, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Mrs C.L. Forster Funeral Home Inc.</b>			25. DATE RECD. BY LOCAL REG. <b>8-18-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
K. L. Shireman



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 *J. Vigil Herrick* .....

Licensed Embalmer No. *3599* .....

P. O. Address *St. Louis, 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.