

Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033016  
STATE FILE NUMBER  
4038

FILED SEP 16 1958 (Registration District No. 149 Primary Registration District No. 002 Registrar's No. 4038)

|   |                           |   |   |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY JACKSON  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MISSOURI b. COUNTY JACKSON                                |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN KANSAS CITY  |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN RAY TOWN 9000   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION ST. JOSEPHS HOSP.  |                           | Length of stay in 1b<br>10 DAYS   | d. STREET ADDRESS (If outside, give location)<br>5920 Hedges ST.      |
| 3. NAME OF DECEASED (Type or print)<br>First MIDDLE Last<br>GRACE A. STOKLEY  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>Aug. 21-1958                    |
| 5. SEX<br>FEMALE  | 6. COLOR OR RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Nov. 7-1878                                       |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  | 9. AGE (In years last birthday)<br>79                                 |
| 11. BIRTHPLACE (City and state or country)<br>QUINCY, ILLINOIS  |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 13a. FATHER'S NAME<br>JAMES A. TAGGERT  |                           | 13b. MOTHER'S MAIDEN NAME<br>LOUISE UNKNOWN   | 14. NAME OF HUSBAND OR WIFE<br>MILTON L. STOKLEY                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>NO   |                           | 16. SOCIAL SECURITY NO.<br>NONE   | 17. INFORMANT<br>MRS. W. B. RAGAN-5920 HEDGES ST.                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Degeneration<br>DUE TO (b) Arteriosclerosis<br>DUE TO (c)<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>Fracture of Right Hip and Right Forearm 8/17/58 |                           |   | INTERVAL BETWEEN ONSET AND DEATH<br>2 mo.<br>2 years<br>4221F         |
| 20a. ACCIDENT <input checked="" 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.)<br>Patient fell in living room of her residence                 |   |
| 20c. TIME OF INJURY<br>Hour a.m. Month, Day, Year<br>9 a.m. 8/17/58   |                           | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Home  |                           | 20f. CITY, TOWN, OR LOCATION<br>Raytown   |   |
| 20g. COUNTY<br>Jackson  |                           | 20h. STATE<br>Mo.   |   |
| 21. I attended the deceased from<br>Death occurred at Aug 1, 1958 to Aug 21, 1958 and last saw her/him alive on Aug 21, 1958<br>4:10 P. m on the date stated above; and to the best of my knowledge, from the causes stated.  |                           |   |   |
| 22a. SIGNATURE<br>John K. Caldwell M.D.   |                           | 22b. ADDRESS<br>Kansas City, Mo.  |   |
| 22c. DATE SIGNED<br>8/22/58   |                           |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   | 23b. DATE<br>AUG-23-1958  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. HOPE CEMETERY   | 23d. LOCATION (City, town, or county) (State)<br>INDEPENDENCE, KANSAS |
| 24. FUNERAL DIRECTOR<br>1331 BRUSH ADDRESS<br>D.W. NEWCOMERS SONS-KANSAS CITY, MO.  |                           | 25. DATE RECD. BY LOCAL REG.<br>8-22-58   | 26. REGISTRAR'S SIGNATURE<br>Neva Minshall                            |

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

S. 300  
V. 1-57

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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 *Norman W. Thurson* .....

Licensed Embalmer No. *4889* .....

P. O. Address *A. C., 3/0* .....

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.