

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033026

STATE FILE NUMBER

FILED SEP 24 1958

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

4198

300  
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) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		358 CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3003 Cypress</b>		Length of stay in lb <b>40 Yrs.</b>		d. STREET ADDRESS <b>3003 Cypress</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WAYNE</b> Middle <b>M.</b> Last <b>STUBBLEFIELD</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>31st,</b> Year <b>1958</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1892</b>	9. AGE (In years) Last birthday <b>65</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-U.S. Post Office Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Braymer, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Guy Stubblefield</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Emily Mowder</b>		14. NAME OF HUSBAND OR WIFE <b>Ruth E. Stubblefield</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>459-38-4549</b>		17. INFORMANT Address <b>Mrs. Ruth E. Stubblefield, 3003 Cypress</b>				
18. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Franchogenic Carcinoma</b>						16 1/2		
DUE TO (c)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								
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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>								
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		
21. I attended the deceased from <b>25-10-45</b> to <b>8-31-58</b> and last saw her alive on <b>8-31-58</b> Death occurred at <b>1037 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (D, M, or title) <b>E. D. Reese</b>		22b. ADDRESS <b>3309 E 12</b>		22c. DATE SIGNED <b>9-1-58</b>		
23a. BURIAL, CREMATION, REINYAH (Specify) <b>Burial</b>		23b. DATE <b>Sept. 2, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>			
24. FUNERAL DIRECTOR <b>Freeman Mortuary, Kansas City, Mo.</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>9-2-58</b>		26. REGISTRAR'S SIGNATURE <b>vera minshall</b>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *Walter H. Erwin*

Licensed Embalmer No. *4352*  
P. O. Address *H. C. 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.