Health, Welfare Public Service

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FILED FEB 27 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005902
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 813

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1319 E. 19th St. — Length of stay in Ib 65 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1319 E. 19th St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: Nettie Middle: Last: Stern
4. DATE OF DEATH Month Day Year: Feb. 10, 1959
5. SEX: Female
6. COLOR OR RACE: Col.
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: June 22, 1884
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Independence, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME: ~~Albert~~ Geo Williams
13b. MOTHER'S MAIDEN NAME: Betty (unknown)
14. NAME OF HUSBAND OR WIFE: William Stern
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 494-16-5201
17. INFORMANT: Mrs. Opal Williams, Chicago, Ill. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Insufficiency
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chronic Myocarditis
DUE TO (c) Arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Obesity - Senility

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): L. M. Tillman M.D. Deputy Coroner
22b. ADDRESS: 1618 Hyde Ave
22c. DATE SIGNED: 2/12/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/13/59
23c. NAME OF CEMETERY OR CREMATORY: Highland Cemetery
23d. LOCATION (City, town, or county) (State): Kansas City, Missouri

24. FUNERAL DIRECTOR ADDRESS: Badeau, Appleton & Jones, K.C., Mo.
25. DATE RECD. BY LOCAL REG.: 2-12-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

L. M. Tillman

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 Cornelia Gladys Bode

Licensed Embalmer No. 4944

P. O. Address K.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.