

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021710

STATE FILE NUMBER
3047

FILED JUL 8 1959

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

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		c. CITY OR TOWN <i>Kansas City</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>2440 McCloy</i>		d. STREET ADDRESS (If outside, give location) <i>2440 McCloy</i>	
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>A</i> Last <i>STEPHENSON</i>		4. DATE OF DEATH Month <i>6</i> Day <i>21</i> Year <i>59</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-22-81</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Jarvis, Mo</i>
13a. FATHER'S NAME <i>Unknown</i>		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE <i>Jenna O. Stephenson</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>---</i>	17. INFORMANT <i>Eva Snow</i> Address <i>3240 Harrison</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) _____			INTERVAL BETWEEN ONSET AND DEATH <i>4 20/1</i>
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.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____, to _____ and last saw ^{her} him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Hugh H. Owens</i> (Degree or title) <i>Coroner</i>		22b. ADDRESS <i>1034 Realto Bldg</i>	
22c. DATE SIGNED <i>6-22-59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>6-25-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cem</i>	23d. LOCATION (City, town, or county) (State) <i>K.C. Mo</i>
24. FUNERAL DIRECTOR <i>Sebbeta</i> ADDRESS <i>K.C. Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>6-22-59</i>	26. REGISTRAR'S SIGNATURE <i>new minshall</i>

Doctor, coroner, etc. must use only standard nomenclature in new. 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, ORR....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Forrest D. Coldman.....

Licensed Embalmer No. 4714.....

P. O. Address St. Louis.....

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.