

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025455

FILED VS AUG 14 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3695 STATE FILE NUMBER

IDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Jackson</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>Jackson</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital</b>		Length of stay in lb <b>45 years</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>708 Prospect</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>Frank</b>		Middle <b>Stuteville</b>		Last <b>Stuteville</b>		Month <b>7</b> Day <b>28</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/15-1874</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>IRON WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>IRON FACTORY</b>		11. BIRTHPLACE (City and state or country) <b>SALINE COUNTY KAN.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>WILLIAM O. STUTEVILLE</b>		13b. MOTHER'S MAIDEN NAME <b>MARY FRANCES</b>		14. NAME OF HUSBAND OR WIFE <b>IDA MAE STUTEVILLE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>SONIE E. CORUM FOSTER MO.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Infarction of ascending, transverse, &amp;</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>&amp; descending colon of unknown etiology</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)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <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>7-20-59</b> to <b>7-28-59</b> and last saw <sup>BOX</sup> him alive on <b>7-28-59</b> Death occurred at <b>11:54 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Abraham Gelpert M</b>				22b. ADDRESS <b>2100 Cherry</b>		22c. DATE SIGNED <b>7-30-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>July 31-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BROOKING</b>		23d. LOCATION (City, town, or county) (State) <b>RAYTOWN MO.</b>			
24. FUNERAL DIRECTOR <b>MUEHLBACH</b>		ADDRESS <b>6800 TROOST KEMO</b>		25. DATE RECD. BY LOCAL REG. <b>7-30-59</b>	26. REGISTRAR'S SIGNATURE <b>Deva Marshall</b>		

DOCUMENT

BY AFFIDAVIT OF Abraham Gelpert M.D. Medical Certification

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed RE Nichols

Licensed Embalmer No. 4997

P. O. Address KC, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.