

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

19458

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Kaw Primary Registration District No. _____
City Kansas City, Mo (No. St. Joseph Hospital) St. _____ Ward _____

File No. _____
Registered No. 2453

2. FULL NAME

Mrs. Ada Stark
(a) Residence. No. 1323 Benton Blvd. St. 12 Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

5A. HUSBAND (OR) WIFE OF Daniel J. Stark

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 26, 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
54 10 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Mo

10. NAME OF FATHER John A Norquist

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden

12. MAIDEN NAME OF MOTHER Christina Oleen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Dont know

14. INFORMANT Mrs. Bruce B. Smith
(Address) 810 Glead Terrace.

15. FILED 6/2 19 30 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 19 30

I HEREBY CERTIFY, That I attended deceased from June 8 19 30 to June 10 19 30
that I last saw him alive on 6-10 19 30, and that death occurred, on the date stated above, at 11 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Lymphatic Leukemia
of following duration, traction, ds.
11 1/2
CONTRIBUTORY (SECONDARY) tooth for fungoria
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH St. Joseph Hospital
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS Leukato
(Signed) John O. Stowers M. D.
11/1 19 30 (Address) 336-47 1/2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Elmwood Cemetery DATE OF BURIAL 6/12/30
ADDRESS _____

20. UNDERTAKER Freeman Mortuary, 104 W 42nd S

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

5108
10/10/15