

REC'D JUN 8 1939

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

17657  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 395  
 (b) Township Kaw Primary Registration District No. 1002  
 (c) City K. C. Mo. (d) Street No. 3517 Cleveland St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 316 Fred D. Stover  
 (a) Residence, No. 3517 Cleveland St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Elizabeth M. Stover

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 11, 1888

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. min.
	<u>50</u>	<u>9</u>	<u>5</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Cleaner  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hanover, Germany

FATHER  
 13. NAME Fred Stover  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER  
 15. MAIDEN NAME Elizabeth Miller  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Mrs. Elizabeth M. Stover  
3517 Cleveland

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Cabary DATE May 18, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John W. Wagner  
Kansas City, Mo.

20. FILED May 17, 39 M. M. Brown  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 16, 1939

22. I HEREBY CERTIFY, That I attended deceased from May 16, 1939 to May 16, 1939  
 I last saw him alive on May 14, 1939. Death is said to have occurred on the date stated above, at 7:45 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Dilatation of Heart following myeloid degeneration  
Respiration  
 Date of onset 1/2

Other contributory causes of importance:  
Left Parotid Gland  
6 months ago

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) St. Feilinger, M. D.  
 (Address) 715-19 Apple Bldg.

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.

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**