

Registration District No. **399**

Primary Registration District No. **100**

Registrar's No. **4068**

NOV 14 1939

1. PLACE OF DEATH:

(a) County **JACKSON**
 (b) City or town **KANSAS CITY, MO.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **ST. MARYS HOSPITAL**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 WEEKS**
 (Specify whether
 In this community **No RECORD**
 years, months or days)

3. (a) PRINT FULL NAME **WILLIAM A. STEPHENS**

3. (b) If veteran, name war **XXXXX** 3. (c) Social Security No. **XXXX**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife **XXXX** 6. (c) Age of husband or wife if alive **XXX** years

7. Birth date of deceased **AUGUST 15 1879**
 (Month) (Day) (Year)

8. AGE: Years/ Months Days If less than one day
61 2 5 hr. min.

9. Birthplace **Leavenworth, Kansas**
 (City, town, or county) (State or foreign country)

10. Usual occupation **SALESMAN**

11. Industry or business **INSURANCE Co.**

12. Name **No Record**

13. Birthplace **XXXX**
 (City, town, or county) (State or foreign country)

14. Maiden name **No Record**

15. Birthplace **XXXX**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs. Bisby**

(b) Address **Kansas City, Missouri**

17. (a) **Burial** (b) Date thereof **Oct 23, 1939**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **Sheil Funeral Home**
 (b) Address **6606 Independence, K.C.**

19. (a) **10/23/39** (b) **M. M. Grove**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City, Mo**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **522 Norton**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? **XXXXXX** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10/20/1939** day **20**
 year **1939** hour **1:30 pm** minutes **10** M.

21. I hereby certify that I attended the deceased from **10/13/1939**, 19**39**, to **10/20/1939**, 19**39**;
 that I last saw him alive on **10/20/39**, 19**39**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia**

Due to **108**

Due to

Other conditions **Chronic Nephritis**
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

28. Signature **Louis H. Gades** (M. D. or other) **M.D.**
 Address **221 Plaza med Bldg** Date signed **10/21/39**
R.O. Gro

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

35-093

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Primary Registration District No. 1002 Registered No. 4068
 (c) City H.C. (d) Street No. 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

Williams a Stephens
 (a) Residence, No. 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 m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S
 (Write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-15-1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
61 2 5

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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)

FATHER
 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 10/23 1939 M. M. Brown
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 20 1939

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation Date of.....

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? 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?

If so, specify.....

(Signed) Sam H. Snider, M. D.

(Address) 221 Poplar med 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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED.

SUPPLEMENTARY

