

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days
(Specify whether years, months or days)
In this community 53 Years.

8. (a) PRINT FULL NAME John Stevens

3. (b) If veteran, name war No 3. (c) Social Security No. 495-05-2468

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Della Mae Stevens 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased. May 10- 1886
(Month) (Day) (Year)

8. AGE: Years 53 Months 7 Days 24 If less than one day hr. min.

9. Birthplace Clay County, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business -----

12. Name Pate Stevens

13. Birthplace Cooper County, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Ameriza Freddy
15. Birthplace Wyandotte Co., Kansas.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Della Mae Stevens

(b) Address 217 Admiral Blvd., K.C. Mo.

17. (a) Burial (b) Date thereof Jan. 6th, 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cemetery.

18. (a) Signature of funeral director Mrs. C.L. Forster

(b) Address 918 Brooklyn Avenue, City.

19. (a) Jan. 6, 1940 (b) M.M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 217 Admiral Blvd.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 4th
year 1940 hour 7 minute 20 A.M. M.

21. I hereby certify that I attended the deceased from 12-17, 1939, to 1-4-40, 1940;

that I last saw him alive on 1-4-1940, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Resolving lobar pneumonia Duration _____

Due to Left hydronephrosis and pyelonephrosis with pyelonephritis

Due to 108

Other conditions Cerebral edema
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See above

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 _____

23. Signature C. J. DeMarco, M.D. (M. D. or other) 1-4-40
Address Supt. K.C. Gen. Hospital Date signed _____

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

David C. Ferrowing

Licensed Embalmer No. *2724*

P. O. Address *7*

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.