

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1012

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

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: 725 Prospect  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 52 yrs.  
(Specify whether years, months or days)

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. 725 Prospect  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

3. (a) PRINT FULL NAME Mary Christine Stoltz 343

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Femal 5. Color or race white 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Joseph Stoltz 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 23 1856  
(Month) (Day) (Year)

| 8. AGE: | Years     | Months   | Days     | If less than one day |
|---------|-----------|----------|----------|----------------------|
|         | <u>83</u> | <u>6</u> | <u>7</u> | hr. _____ min.       |

9. Birthplace Canton Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

12. Name Jacob Miller

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

14. Maiden name Mary Winterhalter  
On the Atlantic Ocean

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Anna Christine Stoltz

(b) Address 725 Prospect

17. (a) Burial (b) Date thereof Mar. 5 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cem

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

(b) Address 918 Brooklyn Kansas City Mo.

19. (a) 3-4-40 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 3  
year 1940 hour 8 minute 53 AM M.

21. I hereby certify that I attended the deceased from 2/28 1940 to 3/3 1940  
that I last saw her alive on 3/2 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis  
Duration 4 days

Due to 820

Due to Branchial Pneumonia

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 D.R. Russell (M. D. or other) \_\_\_\_\_

Address 2231 S. 8-11 St Date signed \_\_\_\_\_

Dr. Russell 3001 Indp Ave.

Be 7 2 5 D  
2 Will 5

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 me

Registered Apprentice No.

working under my personal supervision.

Signed Denzil C. Browning

Licensed Embalmer No. 2726

P. O. Address W.C. no

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.