S. No. 2
-11-10-39
5-1
FILED JUN 4 1940

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

Dr. John Grace.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18185

Registration District No. 198 Primary Registration District No. 3011 Registrar's No. 86

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Well Apartments. 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 22 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay

(c) City or town Excelsior Springs Mo. (If outside city or town limits, write "RURAL")

(d) Street No. 211 East Excelsior St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME MABEL EWING. 520

3. (b) If veteran, name war X

3. (c) Social Security No. No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec. (Month) 15 (Day) -1879 (Year)

8. AGE: Years 60 Months 5 Days 7 If less than one day hr. min.

9. Birthplace Thomasboro (City, town, or county) Ill. 1 (State or foreign country)

10. Usual occupation Apt. Owner

11. Industry or business

FATHER
12. Name Hugh Stockdale
13. Birthplace Unknown (City, town, or county) England 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) Ireland 5 (State or foreign country)

16. (a) Informant T. H. Ewing

(b) Address

17. (a) burial (Burial, cremation, or removal) (b) Date thereof May 24 (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill

18. (a) Signature of funeral director Herbert Hope

(b) Address Excelsior Springs Mo.

19. (a) May 24th (Date received local registrar) (b) Mrs Rea McCracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22nd year 1940 hour 4 minute 530 M.

21. I hereby certify that I attended the deceased from Jan 17, 1940, to May 7, 1940; that I last saw her alive on May 7, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Decompensated Mitral Insufficiency

Due to

Due to 92W

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

Duration

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? (Specify type of place)

18D

While at work? (e) Means of injury

23. Signature John L. Grace (M. D. or other) MD

Address Excelsior Spgs Mo Date signed 5/22/40

(Licensed Embalmer's Statement on Reverse Side)

DEC 29 1942

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 Herbert Hope, Registered Apprentice No. ..... working under my personal supervision.

Signed Herbert Hope

Licensed Embalmer No. 3199

P. O. Address Excelsior Sprin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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