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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FD AUG 14 1940 399

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. **24326**
Registrar's No. **2936**

Registration District No. _____

Primary Registration District No. **1002**

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:
2806 Campbell Street,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **no.**
(Specify whether years, months or days)

In this community **12 years.**

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. **2806 Campbell St.,**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? **no.** years.

3. (a) PRINT FULL NAME **Mrs. Abbie (Rogers) Stanhope,**

3. (b) If veteran, name war. **no.**

3. (c) Social Security No. **no.**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced. **Widowed.**

6. (b) Name of husband or wife **Frank Stanhope,**

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

7. Birth date of deceased **November 11, 1866**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	73	8	9	hr. min.

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

10. Usual occupation **at home.**

11. Industry or business **X**

12. Name **Daniel Pinkerman,**

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

14. Maiden name **Mary Jones,**

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

16. (a) Informant **Mrs. Gladys Brown,**

(b) Address **2806 Campbell, Kansas City, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7-22-40**
(Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Hope Cemetery.**

18. (a) Signature of funeral director **Stine & McClure,**

(b) Address **3235 Gillham Plaza, K.C., Mo.**

19. (a) **July 22, 1940** (Date received local registrar) (b) *M. M. Mervine* (Registrar's signature)

MOTHER FATHER

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **20**
year **1940** hour **5:25** minute **P** M.

21. I hereby certify that I attended the deceased from **1922**,
19____, to **7-20**, 19**40**

that I last saw her alive on **7-20**, 19**40**,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Uremic Coma -

Due to **Coronary - General Arteriosclerosis**

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy **No**

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

(a) Accident, suicide, or homicide (specify) **No.**

(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 *Wilson Myers* (M. D. or other) _____

Address **Kansas City, Mo.** Date signed **7/20/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 J B Waters

Licensed Embalmer No. 2992

P. O. Address KCMo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. _____
Registrar's No. **2936**

Registration District No. _____

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME *Mrs. Abbey (Rogers) Stanhope*

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
13 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) *7/22/1940* (b) *M. M. Brown*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *July* day *20*
year *1940* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw h..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death *(Cerebral) Coma*
(Coma for 5 days before death -
Due to that proven to be hypertensive
Blow to NPN 4/1/39 29-9 - Wore all -
Cerebral or general
arterio sclerotic
Other conditions.....
(Include pregnancy within 3 months of death) *820*

Major findings:
Of operations.....
Of autopsy *None performed*

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?

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

23. Signature *M. M. Brown* (M. D. or other).....

Address *Kansas City Mo* Date signed *7/14/40*

SUPPLEMENTAL

S-24326