No. 2
11-10-39
-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34408

FILED NOV 12 1939

Registration District No. 1

Primary Registration District No. 1002

Registrar's No. 3924

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

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 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

In this community Life

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. 929 Forest (If rural, give location) 0

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

3. (a) PRINT FULL NAME MARTHA STEMPH

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Wm. F. Stemph

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased March 2, 1883 (Month) (Day) (Year)

8. AGE: Years 57 Months 7 Days 8 If less than one day ..... hr. ..... min.

9. Birthplace Independence, Mo 0 (City, town, or county) (State or foreign country)

10. Usual occupation None 0

11. Industry or business 0

FATHER
12. Name Ben Searcy
13. Birthplace Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Jane Smith
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Wm. Stemph

(b) Address 929 Forest

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-40 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Quirk & Tobin

(b) Address Kansas City, Mo.

19. (a) 10-11-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 10th year 1940 hour 8 minute 25 P. M.

21. I hereby certify that I attended the deceased from 10-10-40, 19..., to 10-10-40, 19...; that I last saw her alive on 10-10-40, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Bilateral uteral obstruction with Bilateral pyonephrosis

Due to Previous treated Carcinoma of cervix with metastases to abdominal lymph nodes.

Other conditions (Include pregnancy within 3 months of death) 48

Major findings:
Of operations
Of autopsy See above

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)

While at work? (e) Means of injury 1

23. Signature Drury R. Thone (M. D. or other)

Address Med. Dir. K.C. Gen. Hospital, K.C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

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