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FILLED JUN 10 1941

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 1798

Registration District No. 399

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:  
2333 Bellefontaine Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution --  
(Specify whether  
In this community 32 Years  
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. 2333 Bellefontaine Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? -- years.

3. (a) PRINT FULL NAME Mr. William Henry Stevens  
(b) If veteran, name war No  
(c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 4th  
year 1941 hour 6 minute P. M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Mrs. Kate Stevens  
6. (c) Age of husband or wife if alive -- years  
7. Birth date of deceased August 20 1862  
(Month) (Day) (Year)

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

8. AGE: Years Months Days If less than one day  
78 8 15 hr. min.

Immediate cause of death  
Chronic myocardial infarction  
Due to Coronary atherosclerosis & Occlusion  
Due to 94a  
Other conditions (Include pregnancy within 3 months of death) 94a

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

10. Usual occupation Laborer

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

12. Name William Henry Stevens

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

14. Maiden name Sarah Jane Gerrick

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

16. (a) Informant Forest Priest  
(b) Address 2333 Bellefontaine

17. (a) Burial (b) Date thereof May 7, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director D. H. Newcomer's Son  
(b) Address 1401 Brush-Creek Blvd.  
19. (a) May 1941 (b) M. M. Cronce  
(Date reported local registrar) (Registrar's signature)

Major findings: Of operations 94b  
Of autopsy \_\_\_\_\_

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 Russell (M. D. or other) 3  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC Mo.

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

**If this body is not embalmed, fact should be so stated above.**