

AUG 16 1949  
Registration District No. 99

Primary Registration District No. 1002

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: Research Hospital  
 (If not in hospital or institution, write street number & location)  
 (d) Length of stay: In hospital or institution 12 hrs.  
 In this community 36 years  
 years, months or days

3. (a) PRINT FULL NAME Frank A. Stoll  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. no  
 4. Sex Male 5. Color or race Wh  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Clara  
 6. (c) Age of husband or wife if alive 78 years  
 7. Birth date of deceased 2-17-1867  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
74 5 2 hr. min.

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

10. Usual occupation Coach Painter

11. Industry or business K. C. T. R. R.

12. Name John

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

14. Maiden name Jennie Cook

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

16. (a) Informant Victor Carl

(b) Address 4900 Colorado

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

(c) Place: burial or cremation Burial

18. (a) Signature of funeral director Bentley Mortuary

(b) Address 5811 Broadway

19. (a) 7-22-41 (b) H. M. Brown  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MO. (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5048 Denver  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19  
 year 1941 hour 9 minute 10 P. M.  
 21. I hereby certify that I attended the deceased from July 2  
1941, to July 19, 1941;  
 that I last saw him alive on July 19, 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory collapse  
 Duration 1 day

Due to Dehydration and Secondary (Nutritional) Anemia 3 7/8

Due to Malnutrition (Alcoholism) and Pellagra 3 Mo

Other conditions Cirrhosis of liver and fatty degeneration of liver

(Include pregnancy within 3 months of death)  
 Major findings: and heart

Of operations 164-174 N.

Of autopsy Cardiac Cirrhosis of liver and fatty degeneration of the liver

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 E. Rosekrantz, Jr. (M. D. or other) D  
 Address Kansas City, Mo Date signed July 21 1941

Dr. Ross Kuyger

**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 Ch. J. Ruffington  
Licensed Embalmer No. 02756  
P. O. Address Ke. C. Mo.

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

24206  
State File No. ....  
Registrar's No. 2748

Registration District No. 399 Primary Registration District No. 1602

1. PLACE OF DEATH  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution Research Hospital  
(d) Length of stay: In hospital or institution  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State..... (b) County.....  
(c) City or town.....  
(d) Street No.....  
(e) Citizen of foreign country?.....

3. (a) PRINT FULL NAME Frank A. Stoll  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month..... year 1941 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from.....  
that I first saw him alive on.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

Duration  
Due to.....  
Due to.....  
Other conditions.....  
Major findings:  
Of operations.....  
Of autopsy.....

7. Birth date of deceased.....  
8. AGE: Years Months Days If less than one day min.

9. Birthplace.....  
10. Usual occupation.....  
11. Industry or business.....

PHYSICIAN  
Underline the cause to which death should be charged statistically.

12. Name.....  
13. Birthplace.....  
14. Maiden name.....  
15. Birthplace.....

16. (a) Informant.....  
(b) Address.....  
17. (a) Burial (b) Date thereof 7-22-41  
(c) Place: burial or cremation.....

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?.....  
(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.....

18. (a) Signature of funeral director.....  
(b) Address.....  
19. (a) 9/11/41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

23. Signature..... (M. D. or other).....  
Address..... Date signed.....

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



