DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33844

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 3780

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: 1135 West 41st Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community: 41 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jasckson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 1135 West 41st Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Flora Ann Stubblefield
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: John R. Stubblefield
6. (c) Age of husband or wife if alive: ---- years
7. Birth date of deceased: May (Month) 23 (Day) 1864 (Year)
8. AGE: Years 77 | Months 4 | Days 15 | If less than one day ____ hr. ____ min.
9. Birthplace: Morgan Town (City, town, or county) Kentucky (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: James H. Wade
FATHER 13. Birthplace: Kentucky (State or foreign country)
MOTHER 14. Maiden name: Nancy Ellen Reid
MOTHER 15. Birthplace: Kentucky (State or foreign country)
16. (a) Informant's own signature: Mrs. Portia Lewallen
(b) Address: 1135 West 41st, K.C.Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/ /41 (Month) (Day) (Year)
(c) Place: burial or cremation: Woodlawn, Indep. Mo.
18. (a) Signature of funeral director: Neale Funeral Home
(b) Address: Kansas City, Kansas
19. (a) 10/9/41 (Date received local registrar) (b) M. M. Broome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 8 year 1941 hour 12 minute 50 P.M.
21. I hereby certify that I attended the deceased from July 1940, 19__, to Oct 8, 1941, that I last saw her alive on Oct 6, 1941 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: mytral insufficiency	19
Due to: recurrent Rheumatic fever	12
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 92 b	
Of autopsy: none	

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
23. Signature: Olof Coleman (M. D. or other) M.D.
Address: 6047 E 15 St. Date signed 10/9/41

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Dr. Olaf Coleman
6321 VE 15th
Be 4462

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 Jimmy S. Huckshorn

Licensed Embalmer No. 4092

P. O. Address Kansas City, Kansas

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.