

No. 2  
-5-42  
-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5514  
936  
Registrar's No.

FILED MAR 5 1943  
149

Registration District No. 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  
(c) Name of hospital or institution 642 Sanford  
(d) Length of stay: In hospital or institution. (Specify whether In this community years, months or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 642 Sanford  
(e) Citizen of foreign country? (Yes or No) 0

3. (a) PRINT FULL NAME Galdie May Stephens  
(b) If veteran, name war no (c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb day 20 year 1943 hour 8 minute 40 P.M.  
21. I hereby certify that I attended the deceased from 2/20/43 that I last saw him alive on 2/20/43 and that death occurred on the date and hour stated above.

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

Immediate cause of death: Acute Cerebral Hemorrhage  
Due to Hypertension  
Other conditions: (Include pregnancy within 3 months of death) 83a

7. Birth date of deceased: Aug 22 1891 (Month) (Day) (Year)  
8. AGE: Years 51 Months 5 Days 28 If less than one day hr. min.

9. Birthplace: Moscow Mo (City, town, or county) (State or foreign country)  
10. Usual occupation: at home

MOTHER FATHER  
11. Industry or business  
12. Name Wm D Stephens  
13. Birthplace Ky - 1  
14. Maiden name Josephine O'neil  
15. Birthplace Mo - 0

PHYSICIAN  
Major findings: Of operations  
Of autopsy  
Underline the cause to which death should be charged statistically.

16. (a) Informant Elona Rundquist  
(b) Address 3332 Olive  
17. (a) Burial (b) Date thereof Feb 23 - 1943 (c) Place: burial or cremation Greenhawn  
18. (a) Signature of funeral director M C R Foster  
(b) Address 918 Brooklyn  
19. (a) 2-23-43 (b) Dr. M. Crow (Date received local registrar) (Registrator's signature)

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?  
23. Signature of Registrar: Harold Sappard (Date signed) 3/22/43  
Address: 1116 Park Hill 9 KC Mo.

Dr. Harold J. Johnson  
1116 Prof. Redmon  
W. 6575 - Rm. 8892

JD

**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 Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address Dr. E. M. J.

**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.**