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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 9306

FILED MAR 20 1943

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1203

**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: 2604 Cleveland /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 45 Yrs.
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson 48 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 2604 Cleveland
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME Silas Hoffman Staley

3. (b) If veteran, name war No

3. (c) Social Security No. 487-12-5589

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife Olive M. Staley

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased June (Month) 19th. (Day) 1870 (Year)

8. AGE: Years 72 ~~75~~ Months 8 Days 19 If less than one day ..... hr. ..... min.

9. Birthplace Princetown (City, town, or county) New York / (State or foreign country)

10. Usual occupation Retired Accountant

11. Industry or business

FATHER
12. Name Jacob Staley /
13. Birthplace ..... (City, town, or county) New York (State or foreign country)

MOTHER
14. Maiden name Sarah Hoffman
15. Birthplace ..... (City, town, or county) New York / (State or foreign country)

16. (a) Informant Mrs. Olive M. Staley
(b) Address 2604 Cleveland, K. C., Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof March 10, '43 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Freeman Mortuary
(b) Address Kansas City, Mo.

19. (a) 3-9-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 8th year 1943 hour 2:15 minute P.M.

21. I hereby certify that I attended the deceased from May 1 May 19, 1942 to May 8, 1943 that I last saw him alive on March 8, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage with hemoplegia — Duration 10 days.

Due to arteriosclerosis 9 yrs

Due to Coronary Thrombosis May 19, 1943

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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 John G. Lapp (M. D. or other) M.D.

Address 1314 Professional Bldg Date signed Mar 9 '43

(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 Clarence H. Chiles

Licensed Embalmer No. 3473

P. O. Address 26 C Moo

**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.**