

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 7 1943
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2231

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:
General Hospital 6
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days
In this community 40 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 3510 E. 12th 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Mildred Storck

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex fe 5. Color or race W 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife George 6. (c) Age of husband or wife if alive Oct 28 1872 years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 10 Months 7 Days 6 13
If less than one day hr. min.

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

10. Usual occupation Housewife
11. Industry or business sum
MOTHER FATHER { 12. Name J. A. Johnson
13. Birthplace Indiana (City, town, or county) (State or foreign country)
14. Maiden name Esthene Kline
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Carl Storck
(b) Address Sum pot above
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/13/43 (Month) (Day) (Year)
(c) Place: burial or cremation Front Hill Cem
18. (a) Signature of funeral director Snou - Mayberry
(b) Address Sum wood Blvd
19. (a) 5-13-43 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 11 day. year 1943 hour 8 minute 10 P. M.

21. I hereby certify that I attended the deceased from April 25 1943 May 11 that I last saw her alive on May 11 and that death occurred on the date and hour stated above.

Immediate cause of death Glomerulonephritis, acute acute hemorrhagic cystitis
Due to localized pelvic peritonitis

Due to 130
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
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) Means of injury
23. Signature Henry R. Stone (M. D. or other)
Address Date signed

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

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

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..... *Ray E. Smith*
Licensed Embalmer No. *2560*
P. O. Address..... *RCM*

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.