

FILED DEC 22 1943

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41301  
Registrar's No. 5166

Registration District No. 179

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: K. C. General Hospital No. 10  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 days  
In this community 30 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Emma Staten

3. (b) If veteran, name war ✓ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife James J. Staten 6. (c) Age of husband or wife if alive 72 years  
7. Birth date of deceased July 29, 1875 (Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days 8 If less than one day hr. min.

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

10. Usual occupation at Home

MOTHER FATHER { 11. Industry or business  
12. Name James Hopkins  
13. Birthplace Kentucky (City, town, or county) (State or foreign country)  
14. Maiden name Mildred Ellis  
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant James J. Staten

(b) Address 1321 Troost

17. (a) Burial (b) Date thereof 12-9-43 (Month) (Day) (Year)  
(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Mo.

19. (a) 12-7-43 (b) R. E. Brown (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City (If outside city or town limits, write "RURAL")  
(d) Street No. 1321 Troost (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December, Day 7, Year 1943 hour 2 minute 40 A.M.

21. I hereby certify that I attended the deceased from December 1, 19 43 to December 7, 19 43 that I last saw her alive on December 7, 19 43 and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to 83 a.m.  
Due to \_\_\_\_\_

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? \_\_\_\_\_

While at work (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Army R. Thom (M. D. or other) 12-7-43  
Address Med. Dir. Gen'l Hosp. Date Signed \_\_\_\_\_

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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 Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address. Kansas City, 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.**