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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAR 27 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11160

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 52

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Independence Sanitarium 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community 1 day years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

(c) City or town ~~Kansas City, Mo.~~ Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 27th & Blue Ridge RFD#9 (3)
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME Stephen Dennis Gier

3. (b) If veteran, name war -- 3. (c) Social Security No. --

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced -- 0

6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased February 25, 1944 (Month) (Day) (Year)

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Kansas City, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation --

11. Industry or business --

FATHER
12. Name Louis Gier
13. Birthplace Valley Falls Kansas /
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Phyllis McHenry
15. Birthplace Detroit Mich. /
(City, town, or county) (State or foreign country)

16. (a) Informant Louis Gier
(b) Address 27th Blue Ridge K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28-44 (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills Cemetery

18. (a) Signature of funeral director Sheil Funeral Home
(b) Address 6606 Indep. Ave. K.C.Mo.

19. (a) 2-28-1944 (Date received local registrar) (b) James W. Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 26
year 1944 hour 5 minute 30 A M.

21. I hereby certify that I attended the deceased from Feb 25, 1944, to Feb 26, 1944
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Endocarditis, valvular Bicuspid valve	1 day
Due to —	
Due to —	
Other conditions — (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Acute Endocarditis Mitral valve	

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 Fred W. Hirsch MD (M. D. or other)
Address Fairmount, Mo. Date signed 2/28/44

(Licensed Embalmer's Statement on Reverse Side)

Dr. Fred Hink, Fairmount, Mo.

10235 Indep.

11 o'clock

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 52

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Stephen D. Gier

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced —

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb. 25 1944
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 26
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Endocarditis Valvular Bicuspid Valve

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death) 157e

Major findings:
Of operations

Of autopsy

Duration
Years
Months
Days

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 Fred W [illegible] (M. D. or other)

Address Date signed

11160