No. 2
JM—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 1 1944

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

36927

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4705

**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 No.2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10-27-44-11-17-44 (Specify whether
In this community 33 years
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson 47

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

(d) Street No. 5621 E. 35th Terrace
(If rural, give location)

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

If yes, name country

**3. (a) PRINT FULL NAME** WILLIAM STEPHENS

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race Negro

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

6. (b) Name of husband or wife Anna L. Stephens

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

7. Birth date of deceased January (Month) 13 (Day) 1887 (Year)

8. AGE: Years 57 ~~66~~ Months 10 Days 4 If less than one day hr. min.

9. Birthplace Little Rock (City, town, or county) Arkansas (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business

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

MOTHER
14. Maiden name Charlotte Andrews
15. Birthplace Little Rock (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital No.2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-44 (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director Flynn + Greenstreet

(b) Address K. C. Mo.

19. (a) 11-22-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov. day 17 year 1944 hour 5:20 minute A. M.

21. I hereby certify that I attended the deceased from October 27, 1944, to Nov. 17, 1944; that I last saw him alive on Nov. 17, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Post-operative Shock

Due to Primary Adenoid Carcinoma of Stomach

Due to

Other conditions
(Include pregnancy within 3 months of death)

46b

Major findings:
Of operations

Of autopsy

Duration

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 [signature] (M.D. or other)

Address Gen. Hosp. #2 600 E. 22nd Date signed 11-18-44

(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 Wm. G. Flynn

Licensed Embalmer No. 4383

P. O. Address 1819 E. 15th K.C. 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.**