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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 8 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2029

Registration District No. 72 Primary Registration District No. 5289 Registrar's No. 6

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Gallatin R/10 No KC
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home R/10 - No KC
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Home (Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay 24
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. R#10 No Kansas City Mo
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME LUANNA STONE

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

4. Sex Fe
5. Color or race Wbk
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife William Lee Stone
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 30 (Day) 1867 (Year)

8. AGE: Years 77 Months 6 Days 29 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country) Ill
10. Usual occupation H. W.
11. Industry or business
FATHER
12. Name William Carney
13. Birthplace (City, town, or county) (State or foreign country) Ky.
MOTHER
14. Maiden name M. Hays
15. Birthplace (City, town, or county) (State or foreign country) Ky
16. (a) Informant Miss Nell Stone
(b) Address No KC Mo R10
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1 45 (Month) (Day) (Year)
(c) Place: burial or cremation Liberty - Mo
18. (c) Signature of funeral director Morton Funeral Home
(b) Address No Kansas City Mo
19. (a) Feb 1 - 1945 (Date received local registrar) (b) Ruth N Henry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29 year 1945 hour 7 minute 25 A.M.
21. I hereby certify that I attended the deceased from Aug 1943, to Jan 1945 that I last saw her alive on Dec 21 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Probable Malignancy
Due to Biliary tract
Due to
Other conditions (Include pregnancy within 3 months of death) DITIONAL PPLEMENTARY INFORMATION REQUESTED
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 0
23. Signature J. W. Webb (M. D. or other) MD
Address NKC Mo Date signed 1-29-45

1021

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 2-7-45

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 John S Morton

Licensed Embalmer No. 4349

P. O. Address No Well

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.

No. 2B
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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. 2Bab

Registration District No. 72 Primary Registration District No. 5289 Registrar's No. 6

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Gallatin Twp. Rural (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 years, months or days)

In this community

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 Luanna Stone

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased June (Month) 30 (Day) 1868 (Year)

8. AGE: Years 77 Months 6 Days 26 If less than one day hr. min.

9. Birthplace (City, town, or county) Ill (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 Jan day 9 year 1945 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 Pneumonia of the Bilateral Hilar Probable Gall Bladder

Due to 2) Probable Ruptured

Due to 3) Possibly Gall Bladder

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 (M. D. or other)

Address Date signed 2-10-45

SUPPLEMENTARY

5-2009