

FILED SEP 10 1945
Registration District No. 149

Primary Registration District No. 1002

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:
Neurological Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks
In this community 2 weeks
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan 71
(c) City or town Versailles
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Marion Ethelbert Stover

3. (b) If veteran, name war. no

3. (c) Social Security No. none

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced single
6. (c) Age of husband or wife if alive _____ years (Day) (Year)
7. Birth date of deceased June 13 1904
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 2 17 hr. min.

9. Birthplace Morgan County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation school teacher

11. Industry or business

12. Name Clark Stover
13. Birthplace Coles County Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Rosa Tipton
15. Birthplace Morgan County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Clark Stover
(b) Address Versailles, Missouri
17. (a) burial (b) Date thereof 9 2 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Freedom Cemetery
18. (a) Signature of funeral director H. F. [Signature]
(b) Address Versailles Mo.
19. (a) 9-1-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 30th
year 1945 hour 7 minute 30 P.M.
21. I hereby certify that I attended the deceased from August 8, 1945, to Aug 30, 1945
that I last saw her alive on Aug 30, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Paralysis
Due to encephalitis acute epidemic
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 37a

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) (e) Means of injury _____

23. Signature W. [Signature] (M. D. or other)
Address 2625 Paseo Date signed 9-1-45

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

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

NOV 23 1954

DEC 29 1952

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.....

Gene D. Bauman
Licensed Embalmer No. *4021*
P. O. Address *Versailles, 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.