

No. 2
-5-43
-17-39
X38671

FILED DEC 21 1945
Registration District No. 318

Primary Registration District No. 1003

State File No. _____
Registrar's No. 10688

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution Missouri Pacific Hospital
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Montgomery

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

(d) Street No. Box 424
(If rural, give location)

(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Chas. Edward Stover

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

3. (c) Social Security No. None

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced w 2

6. (b) Name of husband or wife Mary Elizabeth Gaddis Stover, Dec'd

6. (c) Age of husband or wife if alive 7/20/31 years

7. Birth date of deceased Nov. 30, 1858
(Month) (Day) (Year)

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

87	0	9	hr. min.
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9. Birthplace Centralia, Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Pensioned Scale Inspector

11. Industry or business Mo. Pac. R. R. Co.

MOTHER FATHER

12. Name William Stover

13. Birthplace Jefferson Co., Ind.
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Virginia Robnett

15. Birthplace Marshall Co., Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant Laura B. Ford,

(b) Address Box 424, Coffeyville, Kans.

17. (a) Removal (b) Date thereof 12/10/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Coffeyville, Kans.

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

19. (a) DEC 10 1945 J. F. Bredbeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 9
year 1945 hour 5:30 minute P. M.

21. I hereby certify that I attended the deceased from December 8, 1945, to December 9, 1945.

that I last saw h. alive on December 9, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure Duration 18 hrs.

Due to Chronic myocarditis

Due to _____

Other conditions cerebral hemorrhage 9/3 1 day
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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 Robert J. Lanning (M. D. _____)
Address St. Louis, Mo. Date signed 2/9/45

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

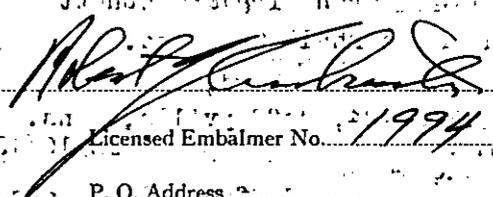
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

working under my personal supervision.

Registered Apprentice No.

Signed



Licensed Embalmer No. 1994

P.O. Address

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.