

FILED JUN 25 1946
Registration District No. **179**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County..... **Jackson**

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

(c) Name of hospital or institution:
General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **less than 24 hrs**
(Specify whether over 6 yrs)

In this community **over 6 yrs**
years, months or days

3. (a) PRINT FULL NAME **Wm S. Stone**

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

3. (c) Social Security No **497-14-3067**

4. Sex **Male** **5. Color or race** **White**

6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **30** years **1887** (Day) (Year)

7. Birth date of deceased **June 30 - 1887**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
68	11	10	hr. min.

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

10. Usual occupation **U.S. Gen. Hosp.**

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant **Coroner's office**

(b) Address **X-C. Mo.**

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** **June 14 - 46**
(Month) (Day) (Year)

(c) Place: burial or cremation **Ind. Poling Cemetery**

18. (a) Signature of funeral director **Ch. Fisher**

(b) Address **2517 Main**

19. (a) 6-14-46 (Date received local registrar) **(b) Geraldine Holmes** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson** **48**

(c) City or town **Kimons City** **3**
(If outside city or town limits, write "RURAL")

(d) Street No. **2001 Base** **8**
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **10** year **1946** hour **11 P.** minute **M.**

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____

that I last saw him _____ alive on _____, 19____

and that death occurred on the date and hour stated above.

Immediate cause of death **Reputy Coroner** Duration _____

Acute Coronary Occlusion

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **9/4**

PHYSICIAN

Major findings: _____

Of operations: _____

Of autopsy: **History & Inspection**

Underline the cause to which death should be attributed 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 **A.E. Usher** (M. Doctor) **MA**

2800 1/2 Main Address Date **6/17/46**

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 J. G. Thorsen
Licensed Embalmer No. 2381
P. O. Address: 2512 Halmer St

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.