

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

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:  
**1603 Linwood**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **no.** (Specify whether years, months or days)

In this community **6 years**

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Jackson**

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

(d) Street No. **1603 Linwood**  
(If rural, give location)

(e) Citizen of foreign country? **no.** (Yes or No)  
If yes, name country **X**

**3. (a) PRINT FULL NAME** **Miss Alice Brooks Poppleton**

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

4. Sex **female** / 5. Color or race **white**

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

6. (b) Name of husband or wife **X** 6. (c) Age of husband or wife if alive **X** years

7. Birth date of deceased **September 6 1867**  
(Month) (Day) (Year)

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

79	6	27	hr. min.
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9. Birthplace **England** (City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business **X**

MOTHER FATHER { 12. Name **Edward Poppleton**

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

{ 14. Maiden name **Sarah**

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

16. (a) Informant **Margaret Hick**

(b) Address **1603 Linwood, Kansas City, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **4-5-47** (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **4-5-47** (Date received local registrar) (b) **Theralline Holmes** (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **April** day **3** year **1947** hour **8:45** minute **P.** M.

21. I hereby certify that I attended the deceased from **3** 19 **47**, to **Apr. 5** 19 **47** and that death occurred on the date and hour stated above.

Immediate cause of death **acute Cardiac Ischemia**

Due to **chronic Myocarditis**

Due to **chronic Myocarditis**

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **93 d**

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) (c) Means of injury **0**

23. Signature **Charles R. Ojias** (M. D. or other) **177 N**

Address **630 W. 11th St. Bldg.** Date signed **4/4/47**

Duration **3 d.**

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

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

*Copy to Ralph Ozias*

Dr. Ralph Ozias

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 Robert H Reed  
Licensed Embalmer No. 3745  
P. O. Address 1/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.