

FILED APR 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7505**Registrar's No. **347**

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 347			
1. PLACE OF DEATH a. COUNTY BUCHANAN				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY BUCHANAN					
b. CITY (If outside corporate limits, write RURAL and give township) ST JOSEPH			c. LENGTH OF STAY (In this place) 45 yrs						
d. FULL NAME OF HOSPITAL OR INSTITUTION 501 E. KANSAS AVE				d. STREET ADDRESS (If rural, give location) 501 E. KANSAS AVE.					
3. NAME OF DECEASED (Type or Print) a. (First) VINNIE			b. (Middle) G.		c. (Last) STOUT		4. DATE OF DEATH (Month) (Day) (Year) March 24, 1949		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW		8. DATE OF BIRTH JUNE 1, 1868		9. AGE (In years last birthday) 80 IF UNDER 1 YEAR Months 9 Days 23 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) RACINE WISCONSIN			12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME UNKNOWN			13b. MOTHER'S MAIDEN NAME UNKNOWN			14. NAME OF HUSBAND OR WIFE JAMES STOUT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME MRS. MINNIE TERESINSKI ADDRESS 501 E. KANSAS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhages ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Hemiplegia - rt 331X II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Emaciation						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from Mar 1, 1948 to Mar 24, 1949 , that I last saw the deceased alive on Mar 21, 1949 , and that death occurred at 7:20 A. m. , from the causes and on the date stated above.									
23a. SIGNATURE E. J. Grant M.D. (Degree or title)				23b. ADDRESS St. Joseph, Mo.			23c. DATE SIGNED 3.26.49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE March 26, 1949		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem		24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.			
DATE REC'D BY LOCAL REG. April 1, 1949		REGISTRAR'S SIGNATURE E. J. Grant 382		25. FUNERAL DIRECTOR'S SIGNATURE Carl A. Clark ADDRESS 1200 Olive St. St. Joseph, Mo.					

(Licensed Embalmer's Statement on Reverse Side)

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

S. No. 300

V. 10-48

Deceased.

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 _____

B. J. Chaney

Student Embalmer No. *294*

working under my personal supervision.

Signed... *B. J. Chaney*.....
Student Embalmer

Signed *Edward Clark*

Licensed Embalmer No. *4235*

P. O. Address *St. Joseph, 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.