

FILED AUG 21 1950

STANDARD CERTIFICATE OF DEATH

State File No. 27131  
3359 Registrar's No.

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY JACKSON   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE MISSOURI b. COUNTY JACKSON |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY                                      |  |
| c. LENGTH OF STAY (in this place) 46 YEARS   |  | d. STREET ADDRESS (If rural, give location) 3520 BALES AVENUE   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH HOSPITAL                              |  |   |  |

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) CLINTON b. (Middle) FRANKLIN c. (Last) STEPHENS |  |  | 4. DATE OF DEATH (Month) (Day) (Year) AUGUST 3 - 1950 |  |  |
|---|--|--|---|--|--|

|             |  |                        |  |  |  |                               |  |                      |  |              |  |            |  |             |  |            |  |
|-------------|--|------------------------|--|--|--|-------------------------------|--|----------------------|--|--------------|--|------------|--|-------------|--|------------|--|
| 5. SEX MALE |  | 6. COLOR OR RACE WHITE |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED |  | 8. DATE OF BIRTH SEPT-11-1881 |  | 9. AGE (In years) 68 |  | 10. MONTHS 0 |  | 11. DAYS 0 |  | 12. HOURS 0 |  | 13. MIN. 0 |  |
|-------------|--|------------------------|--|--|--|-------------------------------|--|----------------------|--|--------------|--|------------|--|-------------|--|------------|--|

|   |  |  |  |   |  |  |  |   |  |  |  |                                     |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|-------------------------------------|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY & PERMANENT AGENT |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY A.J. STEPHENS & COMPANY |  |  |  | 11. BIRTHPLACE (State or foreign country) HOUSTONIA, MISSOURI |  |  |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|-------------------------------------|--|--|--|

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|---------------------------------------|--|--|--|---------------------------------------|--|--|--|--|--|--|--|
| 13a. FATHER'S NAME JOSEPH F. STEPHENS |  |  |  | 13b. MOTHER'S MAIDEN NAME MARY FRENCH |  |  |  | 14. NAME OF HUSBAND-OR WIFE MRS. VERA MILLS STEPHENS |  |  |  |
|---------------------------------------|--|--|--|---------------------------------------|--|--|--|--|--|--|--|

|   |  |  |  |                                     |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|-------------------------------------|--|--|--|--|--|--|--|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No |  |  |  | 16. SOCIAL SECURITY NO. 487-05-6342 |  |  |  | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Vera Mills Stephens |  |  |  | 18. ADDRESS 3520 BALES AVENUE KANSAS CITY, MO. |  |  |  |
|---|--|--|--|-------------------------------------|--|--|--|--|--|--|--|--|--|--|--|

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|---|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute yellow atrophy Liver.   |  |  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH 6 weeks |  |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Cause undetermined |  |  |  |  |  |  |  |  |  |  |  |
|   |  | DUE TO (c)   |  |  |  |  |  |  |  |  |  |  |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                    |  |  |  |  |  |  |  |  |  | 580x                                     |  |

|                        |  |  |  |                                  |  |  |  |  |  |  |  |   |  |  |  |
|------------------------|--|--|--|----------------------------------|--|--|--|--|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION |  |  |  | 19b. MAJOR FINDINGS OF OPERATION |  |  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
|------------------------|--|--|--|----------------------------------|--|--|--|--|--|--|--|---|--|--|--|

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|--|--|--|--|--|--|--|--|---|--|--|--|
| 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) |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|

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|---|--|--|--|--|--|--|--|----------------------------|--|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) |  |  |  | 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 birth to death, 19\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_, m., from the causes and on the date stated above.

|                          |  |  |  |                   |  |  |  |                                  |  |  |  |                           |  |  |  |
|--------------------------|--|--|--|-------------------|--|--|--|----------------------------------|--|--|--|---------------------------|--|--|--|
| 23a. SIGNATURE Kerr M.D. |  |  |  | (Degree or title) |  |  |  | 23b. ADDRESS St. Joseph Hospital |  |  |  | 23c. DATE SIGNED 3 Aug 50 |  |  |  |
|--------------------------|--|--|--|-------------------|--|--|--|----------------------------------|--|--|--|---------------------------|--|--|--|

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|--|--|--|--|----------------------|--|--|--|--|--|--|--|--|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL |  |  |  | 24b. DATE AUG-5-1950 |  |  |  | 24c. NAME OF CEMETERY OR CREMATORY Mt. WASHINGTON CEMETERY |  |  |  | 24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI |  |  |  |
|--|--|--|--|----------------------|--|--|--|--|--|--|--|--|--|--|--|

|                                 |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |
|---------------------------------|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|
| DATE REC'D BY LOCAL REG. 8-5-50 |  |  |  | REGISTRAR'S SIGNATURE Geraldine Palmer |  |  |  | 25. FUNERAL DIRECTOR'S SIGNATURE D.H. Newcomer Sons |  |  |  | ADDRESS 1331-BROWN CREEK KANSAS CITY, MO. |  |  |  |
|---------------------------------|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.

Student Embalmer No.....

Signed *Bernard L. Moran*.....

Signed.....  
Student Embalmer

Licensed Embalmer No. *4250*.....

P. O. Address *N. 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.