

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

30841

State File No.

BIRTH NO. _____ REG. DIST. NO. 112 PRIMARY REG. DIST. NO. 1000 Registrar's No. 989

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Missouri b. COUNTY Buchanan	
b. CITY OR TOWN St. Joseph	c. LENGTH OF STAY (If in place) 1 day	c. CITY OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital		d. STREET ADDRESS (If rural, give location) 3410 Scott St.	

3. NAME OF DECEASED (Type or Print)	a. (First) Clifford	b. (Middle) Lyle	c. (Last) Stone	4. DATE OF DEATH (Month) (Day) (Year) September 15, 1952
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH December 31, 1902	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter	10b. KIND OF BUSINESS OR INDUSTRY paint company	11. BIRTHPLACE (State or foreign country) Fordland, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Stone	13b. MOTHER'S MAIDEN NAME Lucy Parmer	14. NAME OF HUSBAND OR WIFE Ruth
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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. unk.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Ruth Stone, 3410 Scott, St. Joseph, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7 mo
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic Ca Lung St		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 162X	20. AUTOPSY? YES <input checked="" 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?
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22. I hereby certify that I attended the deceased from 3-29, 1952, to Sept 15, 1952, that I last saw the deceased alive on Sept 15, 1952, and that death occurred at 3:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE Dr. L. St. Jenson	(Degree or title) MD	23b. ADDRESS St. Joseph Mo.	23c. DATE SIGNED 9-16-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 9/17/1952	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph Missouri
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DATE REC'D BY LOCAL REG. Sept. 18, 1952	REGISTRAR'S SIGNATURE Carl C. Pascoe	25. FUNERAL DIRECTOR'S SIGNATURE Hester-Bauman Funeral Home	ADDRESS St. Joseph, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

117
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1/2 7/20/20

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *William Gardner*

Licensed Embalmer No. *4535*

P. O. Address *3195 10th 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.