

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6322

State File No.

FILED FEB 18 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 454

1. PLACE OF DEATH
a. COUNTY JACKSON

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
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

d. FULL NAME OF HOSPITAL OR INSTITUTION 100 E. 36 ST. missing home

d. STREET ADDRESS (If rural, give location) 7312 CHESTNUT 3898

3. NAME OF DECEASED
a. (First) AMY b. (Middle) MAUDE c. (Last) STOCKTON

4. DATE OF DEATH JAN. 23 1953

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH 20 MAR. 1884

9. AGE (In years last birthday) 68 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE

11. BIRTHPLACE (City and State or Foreign Country) GREEN CITY, MISSOURI

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME BOONE RILEY

13b. MOTHER'S MAIDEN NAME VIRGINIA SAMUELSON

14. NAME OF HUSBAND OR WIFE WILLIAM A. STOCKTON

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. X X X X X X X

17. INFORMANT'S SIGNATURE OR NAME W.A. STOCKTON ADDRESS 7312 CHESTNUT K.C. MO.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral Bronchial Pneumonia
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Colic
DUE TO (c) Nephritis
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

2 Weeks

593X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

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)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-7, 1952, to Jan 22, 1953, that I last saw the deceased alive on Jan 22, 1953, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE D. F. Weinberg DO (Degree or title)

23b. ADDRESS 7204 Proyer

23c. DATE SIGNED 1/23/53

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 24 JAN.

24c. NAME OF CEMETERY OR CREMATORY FLORAL HILLS

24d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.

DATE REC'D BY LOCAL REG. 1-23-53

REGISTRAR'S SIGNATURE Heraldine Smith

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FLORAL HILLS MEMORIAL CHAPELS K.C.

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

4

5204 *Prague - V* *1st Floor*

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 *Lloyd C. McCord*

Licensed Embalmer No. *4853*

P. O. Address *H. C. M.*

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.