

FILED DEC 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41238**  
**5563**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Bates</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Kansas City</b>		c. CITY OR TOWN <b>Amsterdam</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>8 wks</b>		STREET ADDRESS (If rural, give location) <b>Rural</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Trinity Lutheran Hosp.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>BERTHA</b>	b. (Middle) <b>ELIZABETH</b>	c. (Last) <b>STEPHENS</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>12 2 54</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 2, 1887</b>
9. AGE (In years last birthday) <b>67</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Kansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Marion Kershner</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Barton</b>	
14. NAME OF HUSBAND OR WIFE <b>John Stephens</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>John Stephens, R.F.D Amsterdam, Mo</b>		ADDRESS	
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) <b>Pneumonia Diffuse - Bacterial</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Ceases - Post Hepatic, Medietical 3 wks</b> DUE TO (c) <b>Ruptured Appendix</b> 8 wks II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>5501</b>	
19a. DATE OF OPERATION <b>10-7-54</b>	19b. MAJOR FINDINGS OF OPERATION <b>Ruptured Appendix with Unresolved Peritonitis</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <b>Fancy City Jackson Mo</b>	
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 <u>10-7</u> , 19 <u>54</u> , to <u>12-2</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>12-2</u> , 19 <u>54</u> , and that death occurred at <u>3:25 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Name of title) <b>Earl R. Knox</b>		23b. ADDRESS <b>224 West 24th</b>	23c. DATE SIGNED <b>12-3-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>12-5-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Scott Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Amsterdam, Mo.</b>
DATE REC'D BY LOCAL REG. <b>12-3-54</b>	REGISTRAR'S SIGNATURE <b>Neva Minshall</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wagner Funeral Home, R 6 Mo.</b>	

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

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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.....  
Signature of Student Embalmer

Signed *A. R. Hansen*

Licensed Embalmer No. *412*

P. O. Address *K. C.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.