

FILED JUL 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22411**
2855

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar No. _____

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 town(ship)) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 60 yrs.		e. STREET ADDRESS (If rural, give location) 306 So. Topping	
d. FULL NAME OF HOSPITAL OR INSTITUTION 306 So. Topping			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Louis	b. (Middle) Henry	c. (Last) Stine	July 3 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 29 1876	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	11. BIRTHPLACE (City and State or Foreign Country) Higginville, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME H. F. Stine	13b. MOTHER'S MAIDEN NAME Viola Cooper	14. NAME OF HUSBAND OR WIFE Belle Stine
---------------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) NO	16. SOCIAL SECURITY NO. 494-16-4236	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Belle Stine - 306 So. Topping
--	--	---

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, atherosclerosis, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion		Sudden
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Sclerosis DUE TO (c) _____		2-3 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4201

19a. DATE OF OPERATION	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 Jan, 1873, to July 3, 1955, that I last saw the deceased alive on Dec 14, 1954, and that death occurred at 400 P. m., from the causes and on the date stated above.

22a. SIGNATURE Paul A. Kienberger MD (Degree or title)	23b. ADDRESS 5246 St John	23c. DATE SIGNED 7-5-55
---	----------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 6 1955	24c. NAME OF CEMETERY OR CREMATORY Floral Hills	24d. LOCATION (City, town, or county) (State) Kansas City Missouri
---	------------------------------	--	---

DATE REC'D BY LOCAL REG 7-5-55	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FLORAL HILLS MEMORIAL CHAPELS INC. K. C. MO
---------------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

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

my 8/12/19
embalmer

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 *W. C. McCall*.....

Licensed Embalmer No. *485*.....

P. O. Address *W. 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.