

Health,  
Welfare  
Public  
Service

300  
1-57

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036635  
STATE FILE NUMBER

FILED OCT 23 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4717

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE* (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City Mo</u>		c. CITY OR TOWN <u>Kansas City Mo</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Marys Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>4414 Elmwood</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs Elsie Evaline Stephens</u>		4. DATE OF DEATH Month Day Year <u>10-3-1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home Cass Co. Missouri</u>	11. BIRTHPLACE (City and state or country) <u>U S A</u>
13a. FATHER'S NAME <u>John Henry Hammonds</u>		13b. MOTHER'S MAIDEN NAME <u>Miriam Ann Davenport</u>	14. NAME OF HUSBAND OR WIFE <u>John Stephens</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Charles W Stephens 4414 Elmwood</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>26 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Spontaneous perforation of caecum</u> DUE TO (c) <u>Carcinoma of hepatic flexure of colon primary</u> <u>Dilatation of esophagus - malignant (?)</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>153'</u>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>10-25-51</u> to <u>10-3-58</u> and last saw her alive on <u>10-3-58</u> Death occurred at <u>2:00 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Fred H. Lundgren Jr MD</u>		22b. ADDRESS <u>315 Nichols Road</u>	22c. DATE SIGNED <u>10-4-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-7-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orient Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Harrisonville MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>France-Warnall Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>10-6-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

Fred H. Lundgren, Jr. use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.



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 *Russell N. Fran* .....

Licensed Embalmer No. *425* .....  
P. O. Address *K 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.