

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017968

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2498

300  
-57

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>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Lutheran Hosp.</b>		d. STREET ADDRESS <b>3611 Walnut</b>	
Length of stay in lb <b>50 years</b>		(If outside, give location) <b>Reside on Farm</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Lida</b> Middle <b>Stone</b> Last <b>Stone</b>			4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1959</b>		
--	--	--	---	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1873</b>	9. AGE (In years last birthday) <b>86</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
----------------------	-------------------------------	---	--------------------------------------	---	---	---

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	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	-----------------------------------	--	---

13a. FATHER'S NAME <b>Herman E. Hoelke</b>	13b. MOTHER'S MAIDEN NAME <b>Laura Heil</b>	14. NAME OF HUSBAND OR WIFE <b>John Stone</b>
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>486-07-2467D</b>	17. INFORMANT <b>Mrs. Rose Wilson</b> Address <b>Kansas City 4104 Warwick Missouri</b>
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fibrous Pleurisy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Infarct of Lung</b>	<b>1 week</b>
	DUE TO (c) <b>Arteriosclerosis, Generalized</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Malnutrition</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 <b>0</b> a.m. <b>0</b> 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 <b>Missouri</b> STATE <b>Mo.</b>
---	--	--	---

21. I attended the deceased from <b>Oct. 1958</b> to <b>5-17-59</b> and last saw her/him alive on <b>5-17-59</b> Death occurred at <b>5-17-59</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) <b>Otto W. Teel M.D.</b>	22b. ADDRESS <b>4301 Main St. KC Mo</b>	22c. DATE SIGNED <b>5-17-59</b>
---	---	---------------------------------

23a. BURIAL, CREMATION, or other disposal <b>CREMATION</b>	23b. DATE <b>5/20 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>D.W. Newcomers Sons</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
--	----------------------------	---	---

24. FUNERAL DIRECTOR OR ADDRESS <b>1331 Brush Creek Blvd. D.W. Newcomers Sons Kansas City, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>5-19-59</b>	26. REGISTRAR'S SIGNATURE <b>Olva Minshall</b>
--	---	--

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Otto W. Teel

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 *Harold G. Colter*

Licensed Embalmer No. *3035*  
P. O. Address *.....*

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.