

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-023443<sup>✓</sup>

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3158

STATE FILE NUMBER

FILED JUL 6 1962

VS 300 Rev. 4/59	DATE AMENDED	1	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	DOCUMENT
281502		3		
4 1		4		
5 2		5		
6		6		
7 0		7		
8 2		8		
9331X		9		
10		10		
11		11		
1286-0		12		
13		13		

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>		a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in lb <b>21 Days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hyde Park Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>1835 N. 49th Street</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <b>Myrtle</b> Middle <b>Stevens</b> Last <b>Stevens</b>		Month <b>June</b> Day <b>14</b> Year <b>1962</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>4-4-1882</b>
9. AGE (last birthday) <b>80 Yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HR	
		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (City and state or country) <b>St. Joseph, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>William E. Fransue</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Gatewood</b>	
14. NAME OF HUSBAND OR WIFE <b>Robert Stevens</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>None</b>	
17. INFORMANT <b>Mrs. Robert Walsh</b>		Address <b>1835 N. 49th St. K.C. Ks.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>			<b>2 d</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebrovascular accident</b>			<b>2 months</b>
DUE TO (c) <b>Generalized Arteriosclerotic Disease</b>			<b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>XXX</b>			PART III. If deceased was female was there a pregnancy in last 90 days.
			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 a.m. p.m. Month, Day, Year			
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 <b>June 10, 1962</b> to <b>June 15, 1962</b> and last saw her alive on <b>June 14, 1962</b>		Death occurred at <b>7:18 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>Wm H. Goodson</i> (Degree or title)		22b. ADDRESS <b>730 Prof Bg Kansas City 6, Mo.</b>	22c. DATE SIGNED <b>6/15/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-15-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Plattsburg, Missouri</b>
24. FUNERAL DIRECTOR <b>Stine &amp; McClure Kansas City, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>6-15-62</b>	26. REGISTRAR'S SIGNATURE <i>Ruth N Long</i>

USE BLACK INK OR TYPEWRITER RIBBON

SHOULD READ

BY AFFIDAVIT OF

Wm H. Goodson MEDICAL CERTIFICATION

Dr. William H. Storkson Jr.  
112-3434  
730 Prof. Bldg.  
2:30 - 4:30 p.m.

MS JUL 9 1962

**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 Behan W Meeker

Licensed Embalmer No. 5078

P. O. Address KC, Mo

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.