. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 15 1945

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 12521

Registrar's No. 1931

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4-11-45-4-28-45
(Specify whether years, months or days)
In this community 2 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1019 Paseo
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME EMMA STOREY
3. (b) If veteran, name war No
3. (c) Social Security No. Don't know
4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Charles.
6. (c) Age of husband or wife if alive years
7. Birth date of deceased August (Month) 11 (Day) 1867 (Year)

8. AGE: Years 77 | Months 8 | Days 17 | If less than one day ___ hr. ___ min.

9. Birthplace Liberty (City, town, or county) Missouri (State or foreign country)
10. Usual occupation None
11. Industry or business

MOTHER FATHER
12. Name Mose Waller
13. Birthplace (City, town, or county) Ky. (State or foreign country)
14. Maiden name Angeline Lewis
15. Birthplace Liberty (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Record Clerk
(b) Address Gen. Hosp. #2
17. (a) Burial (Burial, cremation, or removal), (b) Date thereof 5-2-45 (Month) (Day) (Year)
(c) Place: burial or cremation Liberty Harrison Cemetery
18. (a) Signature of funeral director Tellyson & Greenstreet
(b) Address 1819 E. 18th K.C. Mo.
19. (a) 5-1-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28 year 1945 hour 5:28 minute A M.
21. I hereby certify that I attended the deceased from April 11 1945 to April 28 1945; that I last saw her alive on April 28 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebro Vascular Accident	
Due to: Cerebral Arteriosclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature H C Stinson (M. D. or other)
Address Gen. Hosp. #2 Date signed 4-30-45

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed W. G. Flynn

Licensed Embalmer No. 4383

P. O. Address 1819 E. 15th

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 this body is not embalmed, fact should be so stated above.