WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Linn

Township _____ or Village _____ or City Brookfield (No. 558 S Main St.; 4 Ward)

Registration District No. 496 File No. 14127

Primary Registration District No. 3025 Registered No. 44

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Margaret Stevenson

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: April (Month) 27 (Day), 1912 (Year)

AGE: _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ___ hrs. or 10 min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Brookfield Mo

PARENTS

NAME OF FATHER: Homer Stevenson

BIRTHPLACE OF FATHER (City or town, State or foreign country): Chillicothe

MAIDEN NAME OF MOTHER: Marvell Buell

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Brookfield Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Homer Stevenson

(ADDRESS) Brookfield Mo

Filed Apr. 28, 1912 H. H. Pratt, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 27 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from April 27, 1912, to April 27, 1912, that I last saw her alive on April 27, 1912, and that death occurred, on the date stated above, at 9 P.m.

The CAUSE OF DEATH* was as follows:

Asphyxiation

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(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) Retarded delivery.

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. D. Stundley M. D.

April 28, 1912 (Address) Brookfield Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery.

DATE OF BURIAL: 4-28, 1912

UNDERTAKER: R. N. Bowden

ADDRESS: Brookfield Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ *or* Village _____ *or* City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____ (Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____ (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS