

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

Do not use this space.

2286-a

1. PLACE OF DEATH

County St Clair
Towship Orciolo
City..... (No..... St..... Ward)

Registration District No. 765
Primary Registration District No. 6266

File No.....
Registered No. 5

2. FULL NAME

William Riley Stout

(a) Residence. No..... St..... Ward.....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male | w | married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Sara C Stout

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

March 29 - 1850

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>77</u>	<u>9</u>	<u>13</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... retired
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

Centerville
Lopca

(STATE OR COUNTRY)

10. NAME OF FATHER

John Stout

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Don't know

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Anna Roads

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Don't know

(STATE OR COUNTRY)

14.

INFORMANT (Address)

D. F. Corbin
Orciolo Mo

15.

FILED

3-1-18 Reese's

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Jan 14 1928

17.

I HEREBY CERTIFY That I attended deceased from Jan 13, 1928, to Feb 7, 1928, and that I last saw him alive on Feb 19, 1928, and that death occurred, on the date stated above, at 6:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic nephritis

CONTRIBUTORY (SECONDARY)

121
129 W

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 Did an operation precede death..... no DATE OF.....

WAS THERE AN AUTOPSY..... no

WHAT TEST CONFIRMED DIAGNOSIS..... clinical

(Signed)..... W. H. Reese, M. D.

2/5, 1928 (Address) Orciolo Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

County farm 2-16 1928

20. UNDERTAKER

ADDRESS

W. R. Smith

N. B.—Every item of information should be carefully supplied. A.S. stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION.

328

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Clair Registration District No. 965- File No. _____
 Township Osceola Primary Registration District No. 6266 Registered No. 3-
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

William Riley Stout
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. FILED 3-1-28 R. Stevens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 1928

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D. _____, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL _____ 19____

20. UNDERTAKER W. R. Smith ADDRESS Osceola

SUPPLEMENTARY

PHYSICIANS should sign EXACTLY. PREVIEW is very important. /o
 should be carefully supplied. AGE must be properly classified. Exact statement of OCCUPATION
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-2286a