AUG 23 1928

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

Do not use this space.

Crane

File No. 23578

Registered No. 121

1. PLACE OF DEATH

County: Greene Registration District No. 321

Township: Washington Primary Registration District No. 3345

City: ~~(If within city limits)~~ (No. ~~Rogersville Rt 2~~ St. ..... Ward)

2. FULL NAME: Austin Stone

(a) Residence. No. Rogersville Rt 2 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: Wh

5. ~~SINGLE, MARRIED, WIDOWED~~ OR DIVORCED (*write the word*): DIV

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 16 1858

7. AGE: Years 70 | Months 0 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

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): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Rogersville
(STATE OR COUNTRY): Mo.

PARENTS

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: A. L. Stone
(Address): Rogersville Mo.

15. FILED 8/3 1928 M L Turner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-11 1928

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1928, to July 11, 1928, that I last saw him alive on June 30, 1928, and that death occurred, on the date stated above, at 1 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
1 Exhaustion from right unilateral paralysis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Unknown
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) T W B Crane, M. D

7/11, 1928 (Address) 318½ College

*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: Hodson Cem | DATE OF BURIAL: 7/11 1928

20. UNDERTAKER: Alva L. Schweyer | ADDRESS: 534 8th St.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County: Greene — Registration District No.: 321 — File No.:

Township: Washington — Primary Registration District No.: 34444 — Registered No.: 12

City: (No. ..... St. ..... Ward)

2. FULL NAME: Austin Stowe

(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 (*write the word*): Wid

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
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN): Don't know
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER: Don't know

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

14. INFORMANT
(Address)

15. FILED 8/3, 19.... M L Turner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-11-1928

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:

.....
.....
.....
.....(duration)....yrs. ....mos. ....ds.

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 | ADDRESS

SUPPLEMENTARY

REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-23578