

CERTIFICATE OF DEATH

19105

PLACE OF DEATH

County Genesee
 Township Albany
 City Albany (No. St. Ward)

Registration District No. 309
 Primary Registration District No. 4185

File No.
 Registered No.

2. FULL NAME Shurman A Stevens

(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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 1 1930

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Husband of Mrs Alta Stevens

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to June 1, 1930, that I last saw him alive on May 27, 1930, and that death occurred, on the date stated above, at 12:40 a. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 10 - 1843
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
87 5 21

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired Farmer Stockman
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer Hillsville Ohio

CONTRIBUTORY (SECONDARY) 74001
 (duration) yrs. mos. ds.
 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 19. DID AN OPERATION PRECEDE DEATH? no DATE OF
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? ✓
 (Signed) J. E. Graham, M. D.

10. NAME OF FATHER A & W Stevens

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

12. MAIDEN NAME OF MOTHER Rachel Mills

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

June 20 1930 (Address) Albany - 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.

14. INFORMANT S. A. Stevens junior
 (Address) Albany Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Grand View DATE OF BURIAL June 2 1930

15. June 20 1930 W. T. Martin REGISTRAR

20. UNDERTAKER F. R. Shockey ADDRESS Albany Mo.

Exact statement of OCCUPATION is very important. Property classified.

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**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 Gentry Registration District No. 309 File No.
 Township Albany Primary Registration District No. 4185 Registered No.
 City Albany (No.) Si. Ward)

2. FULL NAME Sherman A. Stevens
 (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

MEDICAL CERTIFICATE OF DEATH

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) Dec 9 1840

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
89 5 21

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)
 (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)

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 1 1930

17. I HEREBY CERTIFY, That I attended deceased from to 19....., 19....., and 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.

14. INFORMANT (Address)

15. July 2, 1930 W. T. Martin REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 ADDRESS

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 Exact statement of OCCUPATION is very important.

S-19105