

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

Do not use this space.

29836

**1. PLACE OF DEATH**

County Cedar  
Township Burlow  
City (No.)

Registration District No. 164  
Primary Registration District No. 5229

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

John Thomas Stoups  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)  
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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-16-1863

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	68	3	22	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. Insurance Business  
(b) General nature of industry, business, or establishment in which employed (or employer). Owner  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Foley mo.  
(STATE OR COUNTRY) Cedar co mo

10. NAME OF FATHER John Calvin Stoups

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Keokuk  
(STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Allie Bray

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

14. INFORMANT. J. C. Stoups  
(Address) Genoa Spgs mo.

15. FILED 7-7-31 F. M. Davis  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-9 1931

17. I HEREBY CERTIFY, That I attended deceased from 6-5, 1931, to 6-9, 1931, that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at 3:15 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Accidental death. Caused by fall on back of head with concussion of brain and fracture of skull (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) 18 hrs 19 hrs 1860 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? H. L. Swanson M.D.  
(Signed) \_\_\_\_\_  
, 19\_\_\_\_ (Address) Genoa Springs, 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 Genoa Spgs Mo. Anna Edu DATE OF BURIAL 6/12 1931

20. UNDERTAKER Mitchell's Lumber Co ADDRESS Genoa Spgs Mo

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.

JUL 23 1931



**MISSOURI STATE BOARD OF HEALTH  
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Cedar Registration District No. 164  
 Township Benton Primary Registration District No. 5229  
 City No. St.  Ward

File No. 20836  
 Registered No.

**2. FULL NAME**

John Thomas Stamps  
 (a) Residence No.  St.  Ward   
 (Usual place of abode)

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. (If nonresident, give city or town and State)

**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. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 7-7-31 F. M. Davis Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9, 1931

22. I HEREBY CERTIFY, That I attended deceased from  to , 19

I last saw h..... alive on , 19..... Death is said to have occurred on the date stated above, at  m.

The principal cause of death and related causes of importance were as follows:

*accidental death caused by fall on back of head and concussion of brain and fracture skull (incident occurred in the town of Park while doing carpenter work of a new hand stand. He fell backwards off of a saw horse and hit head on concrete floor.*

Name of operation..... Date of 1931  
 What test confirmed diagnosis?..... Was there an autopsy? 1931

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify (Signed) H. L. Swanson, M. D.  
 (Address) Levitt Springs, Mo.

**SUPPLEMENTARY**

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

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