

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

Do not use this space.

41168

1. PLACE OF DEATH

County Jackson
Township Frank
City St. Louis (No. 15)

Registration District No. 3002
Primary Registration District No. 3002

File No. _____
Registered No. 5157
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 1512 white St. 15 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 23-1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 2 5

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER John Johnson

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

12. MAIDEN NAME OF MOTHER Anna Stillwagon

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

14. INFORMANT Dave Stillwagon
(Address) 1512 white

15. FILED 17 29 31 M. M. Corone REGISTRAR
Asen

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 28 1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____, 3:00 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Stomatitis 2/Heart

9 13 84
10 13 9 5 13
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) mentally unbalanced
(duration) yrs. mos. ds.

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 Specimen / delivery

(Signed) Sam Corone M. D.
17 29 1931 (Address) Corone

*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 Monett Mo DATE OF BURIAL Dec 31 19 31

20. UNDERTAKER Rose + Henderson ADDRESS 154 Jackson

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.

