

MAR 2 1933

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

Do not use this space.

1. PLACE OF DEATH

65 County Marion
Township Lexington
City..... (No.....)

Registration District No. 5-5-8
Primary Registration District No. 5752

File No. 2370
Registered No. 1 Ward

2. FULL NAME

John Meriel Stuteville

(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 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 Charlotte Stuteville

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Febry 18, 1864

7. AGE YEARS MONTHS DAY If LESS than 1 day, hrs. or min.
68 10 23

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) Farmer
(c) Name of employer.....

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

10. NAME OF FATHER George Stuteville

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Mary McHenry

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Not known

14. INFORMANT Mrs J M Stuteville
(Address) Davis City Iowa

15. FILED 1/19 19. 33 C E Odue
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10, 1933

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1933, to Jan 10 1933 that I last saw h. live on Jan 9 1933, and that death occurred, on the date stated above, at 4:00 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia
108 (duration) yrs. mos. 7 da.

CONTRIBUTORY (SECONDARY) None
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) Bob Reed, M. D.
, 19 (Address) Davis City Iowa

*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 Pleasanton Ia DATE OF BURIAL 1/19/33 19

20. UNDERTAKER F. S. Stewart ADDRESS Leola Ia

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.

