

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

Do not use this space.

15383

1. PLACE OF DEATH

97 County Saline Registration District No. 794
Township Clay Primary Registration District No. 4474
City _____ (No. _____) St. _____ Ward _____

File No. _____
Registered No. 13

2. FULL NAME

(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)

Thomas Jefferson Stivers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 17-1857

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
75 9 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
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) Boone Co Mo.

FATHER 13. NAME Francis Stivers

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

MOTHER 15. MAIDEN NAME Nancy E. Wade

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co Mo.

17. INFORMANT T. M. Stivers (ADDRESS) Marshall Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER J. Wesley Sweeney (ADDRESS) Marshall Mo.

20. FILED Jul 27 1933 W. M. Tully Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug - 29 1933

22. I HEREBY CERTIFY, That I attended deceased from July 10 1933 to April 29 1933
I last saw him... alive on April 28 1933. Death is said to have occurred on the date stated above, at 6 A. M.

The principal cause of death and related causes of importance were as follows:
Eudocystes Choleic
49 B.
17016
J. P. A.
Date of onset 2 yrs.
Other contributory causes of importance:
Spleen Capitis - with
deom Res & enterites.

Name of operation _____ Date of _____
What test confirmed diagnosis? Choleic Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury _____, 19____
Where did injury occur? front
(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? No
If so, specify _____
(Signed) J. E. Beckwood, M. D.
(Address) Stater Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JUN 24 1933

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