

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

Do not use this space.

9198

1. PLACE OF DEATH

County Lafayette
Township Boon
City Higginsville (No. 42.14)

Registration District No. 460
Primary Registration District No. 5-643

File No. _____
Registered No. 20
St. _____ Ward _____

2. FULL NAME John C. Stone

(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

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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 30 - 1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 5 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Expt Profdr at Home
(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) Jackson MO
Jackson

10. NAME OF FATHER Dr W B Stone

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

12. MAIDEN NAME OF MOTHER Louisa Powell

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

14. INFORMANT (Address) _____

15. FILED Apr 1, 1934 H. G. MRR REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/24 1934

17. I HEREBY CERTIFY, That I attended deceased from December 1, 1933, to March 24, 1934 that I last saw him alive on 3/24, 1934 and that death occurred, on the date stated above, at 6 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
High Blood Pressure
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? _____

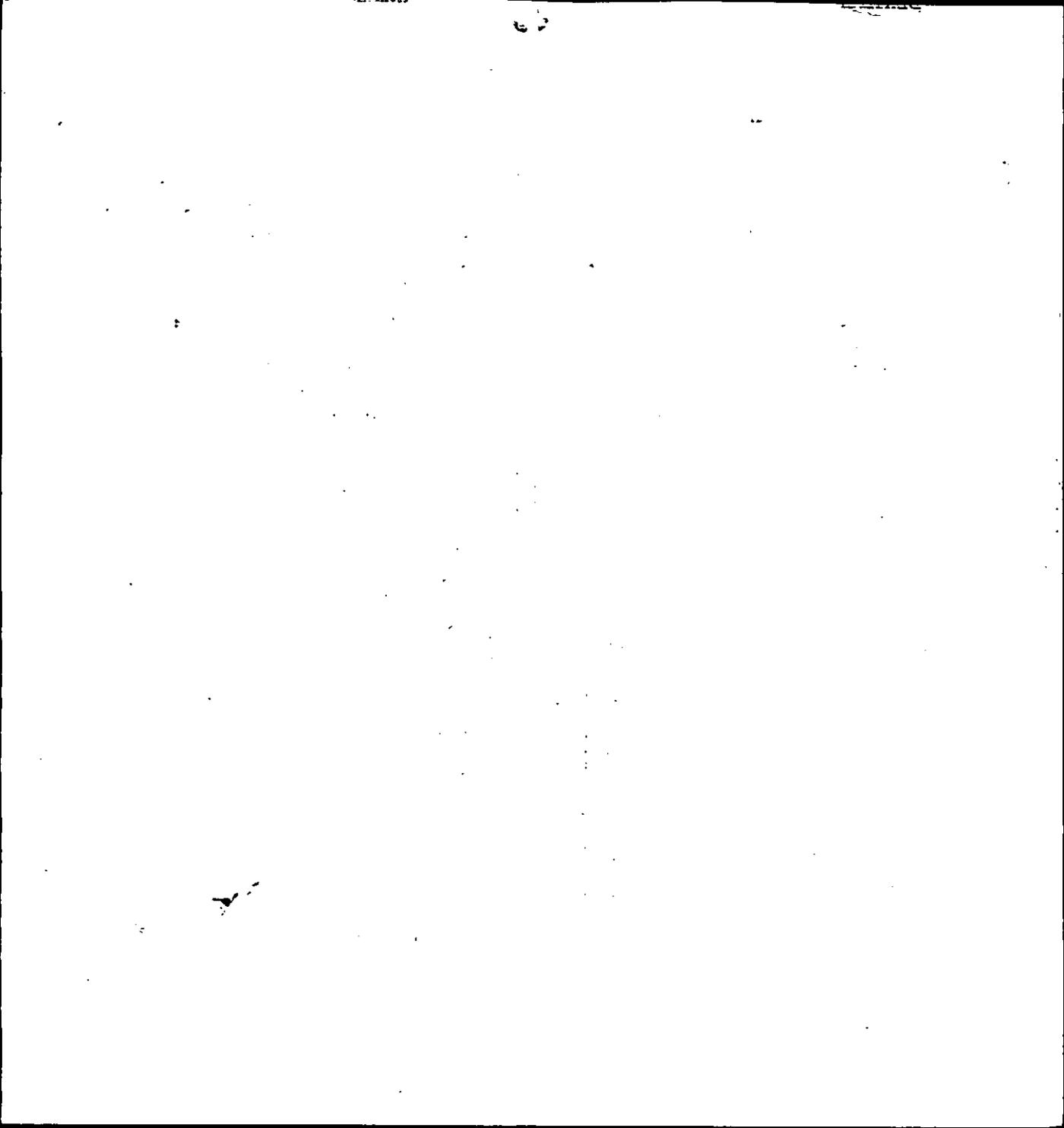
(Signed) F. H. Howard, M. D.
, 19 (Address) Higginsville Mo.

*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 (Forest Hill) H.C. DATE OF BURIAL 3/25 1934

20. UNDERTAKER W. H. Wader ADDRESS Higginsville Mo

124
55
4
1
2
2



**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 L. Fayette
Township
City Waggonville (New)

Registration District No. 460
Primary Registration District No. 4274

File No.
Registered No. St. Ward)

2. FULL NAME

John C. Stave

(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) mar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 24 1934

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

22. I HEREBY CERTIFY, That I attended deceased from

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

19 , to , 19

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

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:

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

Date of onset

Other contributory causes of importance:

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

13. NAME

Name of operation Date of

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

What test confirmed diagnosis? Was there an autopsy?

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

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

Accident, suicide, or homicide? Date of injury , 19

17. INFORMANT (ADDRESS)

Where did injury occur? (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE DATE , 19

Manner of injury

19. UNDERTAKER Att. Hadley (ADDRESS) Waggonville

Nature of injury

20. FILED April 1 1934 J. G. Bruce Registrar.

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

If so, specify

(Signed) , M. D.

(Address)

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

SUPPLEMENTARY

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