

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.

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

Do not use this space.

1. PLACE OF DEATH

County *Greene*

Registration District No. *318*

File No. *2743*

Township

Primary Registration District No. *2001*

Registered No. *1*

City *Springfield*

No. *City Hospital*

St.

Ward

2. FULL NAME *Young L. Stubblefield* *314*

(a) Residence, No. *2118 Taylor* St. Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *20* 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

Prudence Stubblefield

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

Nov. 19, 1848

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

80

1

12

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Carpenter

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)

Nixa, Mo.

FATHER

13. NAME

William Stubblefield

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

Kentucky

MOTHER

15. MAIDEN NAME

Lucinda Stubblefield

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

Kentucky

17. INFORMANT (ADDRESS)

Mrs. J. K. Stubblefield, 2118 Taylor Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Hobbsen Drive* DATE *Jan. 3, 1938*

19. UNDERTAKER (ADDRESS)

F. C. Rye, Springfield, Mo.

20. FILED

Jan 3, 1938 *Chas. U. George* Registrar

MEDICAL CERTIFICATE OF DEATH

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

Jan. 1, 1938

22. I HEREBY CERTIFY, That I attended deceased from

11-2-37, 19... to... 19...

I last saw him alive on *1-1-38*, 19... Death is said

to have occurred on the date stated above, at *9 P* m.

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

*Degenerative Heart Disease
Generalized Arteriosclerosis*

Date of onset

Other contributory causes of importance:

Sanguine Pt. Foot (Arteriosclerotic) *11-2-37*

Name of operation *Amputation Pt. Foot* Date of *12-29-37*

What test confirmed diagnosis? Was there an autopsy? *No*

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? *No*

If so, specify

(Signed)

C. L. Simpson, M. D.

(Address) *Citizen Bank Bldg. Springfield, Mo.*

5710

RECEIVED

FEB 24 1938

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MO. STATE BOARD OF HEALTH