

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

1112  
 Do not use this space.

REC'D FEB 20 1939

**1. PLACE OF DEATH**

(a) County Jackson Registration District No. 395  
 (b) Township Law Primary Registration District No. 1002  
 (c) City Jackson City (d) Street No. 3215 Victor St.  
 (e) Length of residence in city or town where death occurred 14 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **125**

**2. PRINT FULL NAME**

(a) Residence, No. 3215 Victor St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 10, 1939

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John A. Coyle

22. I HEREBY CERTIFY, That I attended deceased from July, 1927, to Jan 14, 1939  
 I last saw her alive on Jan 10, 1939 Death is said to have occurred on the date stated above, at 1 P. m.  
 The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 12, 1857  
 7. AGE YEARS 81 MONTHS 6 DAYS 28  
 if LESS than 1 day, ..... hrs. or ..... min.

Cerebral Hemorrhage  
 Cortical Sclerosis  
 Senility  
 Paralysis of lower extremities  
 Date of onset July - 1927

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. ....  
 9. Industry or business in which work was done, as saw mill, bank, etc. at home  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

Other contributory causes of importance:  
 Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? No.

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

FATHER 13. NAME Andrew Stephenson

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

MOTHER 15. MAIDEN NAME unknown

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

17. INFORMANT (ADDRESS) Mrs. Nellie Bilton  
3215 Victor

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.....

18. BURIAL, CREMATION, OR REMOVAL PLACE Cremation DATE Jan. 12, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) O. H. Newcomer, Son  
Brushcreek & Falls

24. Was disease or injury in any way related to occupation of deceased? None  
 If so, specify.....  
 (Signed) W. H. Stevens M. D.  
 (Address) 1103 E. Armour

20. FILED Jan 11, 1939 M. M. Brown  
 Local Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed..... *Lawrence C*

Licensed Embalmer No. *4031*

P. O. Address *1401 Bunker*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**