

REC'D FEB 21 1939

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

1462

Do not use this space.

1. PLACE OF DEATH

(a) County Andrew Registration District No. 11
 (b) Township Jackson Primary Registration District No. 5013 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred 60 yrs. (If death occurred in Hospital or Institution, write its name instead of street and number) mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Clyde Stephens

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widowed</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 17 - 1878</u>		
7. AGE <u>60</u>	YEARS <u>6</u>	MONTHS <u>13</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>		11. Total time (years) spent in this occupation _____
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year) _____		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Andrew County Mo.</u>		
13. NAME <u>Zaphnath Stephens</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Andrew County Mo.</u>		
15. MAIDEN NAME <u>Sarah Crwson (Crawson)</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Callaway County Mo.</u>		
17. INFORMANT (ADDRESS) <u>Dan Stephens Fillmore Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Gravel wall</u> DATE <u>Feb 3</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>E. C. Breit Savannah Mo.</u>		
20. FILED <u>Feb. 2</u> 19 <u>39</u> <u>Mrs. Addie Barnes</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January -30 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 22 1939, to Jan 30 1939
 I last saw him alive on Jan 26 1939. Death is said to have occurred on the date stated above, at 8/30 p.m.

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

Perforated Gastric Ulcer

Date of onset

Other contributory causes of importance: 117 W

Name of operation _____ Date of _____

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) M. L. Holliday, M. D.11 (Address) Fillmore Mo.

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.

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,

E. C. Breit

, or by

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

Signed

E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah Mo.

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.