

REC'D MAR 23 1939

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH
8024
Do not use this space.

1. PLACE OF DEATH Stone 1
 (a) County Alpine Registration District No. 847
 (b) Township Alpine Primary Registration District No. 6255 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jerina Stallions
 (a) Residence, No. _____ 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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

 5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF Harve Stallions
 (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7/29/1864
 7. AGE YEARS 75 MONTHS _____ DAY 35 If LESS than 1 day, _____ hrs. or _____ min.

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

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) _____

11. Total time (years) spent in this occupation 012. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.FATHER 13. NAME Henry Scates14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't knowMOTHER 15. MAIDEN NAME Mary Donaldson16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know17. INFORMANT (NAME) Harve Stallions
(ADDRESS) Shell Knob Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Owens Cem. DATE 2/16/3919. FUNERAL DIRECTOR (NAME) Eul Dalton (acting)
(ADDRESS) Shell Knob Mo

20. FILED _____, 19 _____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 18 193922. I HEREBY CERTIFY, That I attended deceased from 2/13/39 to 2/14/39I last saw him alive on 2/13/39 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:

Cerebral HemorrhageDate of onset 2 daysOther contributory causes of importance: arteriosclerosis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____

(Signed) L. C. Shegmate M. D.(Address) 761 P. O. Box Spring No.

RECEIVED

District Health Officer No. 6,

District File Number 6-39-519

Date Filed MAR 8 1939

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

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Do not use this space.

1. PLACE OF DEATH

(a) County Stone Registration District No. 847
(b) Township Alpine Primary Registration District No. 6255 Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Jerina Stallions
(a) Residence, No. _____ 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 7 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-14-1939

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-20-1864

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:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
75 25

Cerebral Hemorrhage Date of onset 2 day

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Hoof.
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) _____
11. Total time (years) spent in this occupation _____

arterio sclerosis with
Other contributory causes of importance: _____

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

FATHER 13. NAME Henry Deates

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

MOTHER 15. MAIDEN NAME Mary Donaldson

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

17. INFORMANT Harve Stallion (ADDRESS) Shell Knob, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Owens Cross DATE 2/16/39

19. FUNERAL DIRECTOR Earl Dulan acting (ADDRESS) Shell Knob, Mo.

20. FILED 2-15-1939 J. C. Sheppill Local Registrar.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____

(Signed) L. S. Shumate, M. D.

(Address) Reeds Springs, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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

