

REC'D APR 13 1939

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

12720
Do not use this space.

1. PLACE OF DEATH
 (a) County North 2 Registration District No. 903
 (b) Township Blitchell 1 Primary Registration District No. 4545
 (c) City Grant City, Mo (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME 310 LICETTIE STABE

(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

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the words) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 28, 1957

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 0 22

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

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) over 20 years 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion, Ohio

FATHER 13. NAME Michael Stabe

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chickasha, Okla

MOTHER 15. MAIDEN NAME Margaret Mitchell

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chickasha, Okla

17. INFORMANT Wm Scott (ADDRESS) Grant City Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Blitchell DATE 3/21 1939

19. FUNERAL DIRECTOR (NAME) A.C. Dungee (ADDRESS) Grant City, Mo.

20. FILED 4-8 1939 Red Mill, Mo. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3. 20 1939

22. I HEREBY CERTIFY, That I attended deceased from 9-2 1939, to 3-20 1939
 I last saw her alive on 3-19 1939 Death is said to have occurred on the date stated above, at 6:00 P. m.
 The principal cause of death and related causes of importance were as follows:
Chronic nephritis -
gullstrated -
1936
 Date of onset 1936

Other contributory causes of importance: ✓

Name of operation none Date of _____
 What test confirmed diagnosis? autopsy 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 Chronic nephritis M. D. _____
 (Signed) Wm Scott
 (Address) Grant City Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

RECEIVED
District Health Officer No. 197
District File Number 2-29-366
Filed APR 12 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 Arch C. Dunfee
Licensed Embalmer No. 3252
P. O. Address Grant City, 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.