

1939 AUG 14 1939

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

26205
Do not use this space.

1. PLACE OF DEATH
(a) County Madison Registration District No. 538
(b) Township Twelve mill Primary Registration District No. 6726
(c) City _____ (d) Street No. _____ Registered No. 48
(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.
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME 315 Oscar Stevens
(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 word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 16 - 1925

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
14 4 20

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 6, 1939

22. I HEREBY CERTIFY, That I attended deceased from June 28, 1939 to July 6, 1939
I last saw him alive on July 6, 1939 Death is said to have occurred on the date stated above, at 5 P m.
The principal cause of death and related causes of importance were as follows:
Typhoid fever
Date of onset _____

Other contributory causes of importance:
Spontaneous Intestinal

12. BIRTHPLACE (CITY OR TOWN) Madison Co Mo.
(STATE OR COUNTRY)

FATHER
13. NAME Hugh Stevens

14. BIRTHPLACE (CITY OR TOWN) Madison Co Mo.
(STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME Velma Shaper

16. BIRTHPLACE (CITY OR TOWN) Madison Co Mo.
(STATE OR COUNTRY)

17. INFORMANT Lueta Shaper
(ADDRESS) Saco Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Pisgah DATE July 7, 1939

19. FUNERAL DIRECTOR (NAME) None
(ADDRESS)

20. FILED July 7, 1939 S. C. B. Laughlin 481
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? no
If so, specify _____
(Signed) W. Harry Dawson, M. D.
Forfeited (Address)

Accepted and recorded _____
By E. P. ... (Signature)
Accepted and recorded _____ (Signature)
(Print name and title on Reverse Side)

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, 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 do so with the above constitutes grounds for revocation of license.)

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