

FILED FEB 7

1940

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

3320

Do not use this space.

1. PLACE OF DEATH *Pettis 2*
 (a) County *Pettis 2* Registration District No. *668*
 (b) Township *Sedalia 0* Primary Registration District No. *3039*
 (c) City *Sedalia 0* (d) Street No. *671 E 15* Registered No. *14*
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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 *John Alexander Stevens*
 (a) Residence, No. *671 E 15* 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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Divorced*
- 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Pearl Stevens*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 6, 1860*
7. AGE YEARS *79* MONTHS *5* DAYS *7* If LESS than 1 day,hrs. ormin.
- OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Gen-Business*
 9. Industry or business in which work was done, as saw mill, bank, etc. *Retired*
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Madison Co Indiana*
- FATHER 13. NAME *Joseph Stevens*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Do not know*
- MOTHER 15. MAIDEN NAME *Margaret*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Do not know*
17. INFORMANT (ADDRESS) *Charles Stevens Sedalia*
18. BURIAL, CREMATION, OR REMOVAL PLACE *Mc Lee Chapel* DATE *Jan 15, 40*
19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Mc Laughlin Bros Sedalia Mo*
20. FILED *Jan 15* 19 *40* *Wm Harry Sneed* (Address) *Sedalia Mo*
Legal Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 12, 1940*
22. I HEREBY CERTIFY, that I attended deceased from *Jan 2, 1940* to *Jan 12, 1940*
 I last saw him alive on *Jan 12, 1940* Death is said to have occurred on the date stated above, at *7:20 P.M.*
 The principal cause of death and related causes of importance were as follows:
Double Bunch pneumonia
failure of kidneys.
 Date of onset *Jan 2, 1940*
- Other contributory causes of importance:
arteriosclerosis
chronic myocarditis
hypertension
- Name of operation *none* Date of *none*
 What test confirmed diagnosis? *chest* Was there an autopsy? *no*
23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *no* 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 *none*
 (Signed) *W. H. Casper*, M. D.
 (Address) *Sedalia Mo*

(Licensed Embalmer's Statement on Reverse Side)

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. 8,
District File Number
to Filed 2/7/42

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 Robert H. Reed

Licensed Embalmer No. 3745

P. O. Address Sedalia 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.