

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

4165

Do not use this space.

**1. PLACE OF DEATH**

(a) County Wright Registration District No. 908  
 (b) Township Mt. Grove Primary Registration District No. 4549  
 (c) City Wright (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.

Registered No. 1

**2. PRINT FULL NAME**

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
Samuel R Stillwell  
 (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) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Malinda Stillwell  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March-20-1857  
 7. AGE YEARS 82 MONTHS 9 DAYS 14 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. retired  
 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 \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Denon

FATHER 13. NAME David Henry Stillwell

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Denon

MOTHER 15. MAIDEN NAME Synthia Elliot

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Denon

17. INFORMANT (ADDRESS) Ross Stillwell

18. BURIAL, CREMATION, OR REMOVAL PLACE Fairview Church DATE Jan. 5-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Russell Barber

20. FILED 1-6, 19 40 Bernice Montgomery (Address) \_\_\_\_\_

Local Registrar \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 4 - 1940

22. I HEREBY CERTIFY That I attended deceased from 12-29th 1939, 1939, to Jan 4th 1940, 1940

I last saw him alive on Jan 3rd, 1940. Death is said to have occurred on the date stated above, at 12.30 A.M.

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

Chronic Interstitial Nephritis Date of onset \_\_\_\_\_  
Hyper tension

Other contributory causes of importance: Cystitis

Name of operation XXXXXXX Date of \_\_\_\_\_

What test confirmed diagnosis? Physical 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 \_\_\_\_\_, 1940

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) H. D. France, M. D.

Local Registrar \_\_\_\_\_

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. 6,

District File Number 2410-507

Date Filed FEB 14 1940

**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 Russell Barber

Licensed Embalmer No. 3848

P. O. Address Waterbury, Conn.

**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.**