

APR 23 1940

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

12773
Do not use this space.

1. PLACE OF DEATH

(a) County Wayne Registration District No. 10 20
 (b) Township Pfefferson Primary Registration District No. 6190 Registered No. _____
 (c) City Mc Kee Mo (d) Street No. 21 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 Louisa Stephens

(a) Residence, No. mc Kee Mo 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 Female 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 John Stephens
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 69 3 27
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Keeper
 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) don't know 11. Total time (years) spent in this occupation all life
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

FATHER 13. NAME William Payne 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana
 MOTHER 15. MAIDEN NAME Liza Payne 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Oran Stephens
Mc Kee Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Duniphan Cmty DATE 2-28 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) James Stephens
Mc Kee
 20. FILED Mar 14 1940 J. D. Kinnim 812 (Address) _____
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 27 1940

22. I HEREBY CERTIFY, That I attended deceased from Dec 1 1939 to Feb 27 1940
 I last saw him alive on Dec 15 1940 Death is said to have occurred on the date stated above, at 11:50 p. m.
 The principal cause of death and related causes of importance were as follows:

Pneumonia of
liver and stomach
 Date of onset 2 yrs
 Other contributory causes of importance: none
 Name of operation _____ Date of _____
 What test confirmed diagnosis? none 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 _____
 (Signed) E. J. Edmund M. D.
W. H. Jones M. D.

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.

1 X 1 4025

46

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF FUNERAL SERVICE

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12779

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 1020

Primary Registration District No. 6190

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wayne
(b) City or town Jefferson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Louise Stephens

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years Months Days If less than one _____ hr. _____ min.
69 3 27

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____; that I last saw him alive on _____ 19 _____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral + Stomach Duration _____

(Sent on file)
Due to _____

Due to Down Perfor

Other conditions (Include pregnancy within 3 months of death) 46

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature E. L. Thomas (M. D. or other) _____

Address Jefferson Mo Date signed _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **12773⁷**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **1020**

Primary Registration District No. **6196**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Wayne**
(b) City or town **Jefferson T. P.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location) _____
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Wayne**
(c) City or town **M. Lee**
(If outside city or town limits write "RURAL") _____
(d) Street No. _____ (If rural, give location) _____
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Louise Stephens

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____

Jan 1871
(Month) (Day) (Year)

1871
(Year)

8. AGE:

Years **69**

Months **3**

Days **27**

If less than one day _____ hr. _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Mar 14, 1940**

(Date received local registrar)

(b) **E. L. Elmore**

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **27**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of liver and stomach**

Due to _____

Due to _____

Other conditions **46**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **E. L. Elmore** (M. D. or other) _____

Address **Peppercorn** Date signed _____

SUPPLEMENTAL