

FILED JUN 2 1940

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

18035
Do not use this space.

1. PLACE OF DEATH

(a) County COLLAWAY Registration District No. 104
(b) Township 3 Primary Registration District No. 3008
(c) City FULTON (d) Street No. MISSOURI HOSPITAL #1 St. 131
(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

350 THOMAS T. STONE
(a) Residence, No. JEFFERSON CITY, MO. 0 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) WIDOWED
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF NANCY BOWEN
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 2 1860
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
79 5 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Carpenter
9. Industry or business in which work was done, as saw mill, bank, etc. DK.
10. Date deceased last worked at this occupation (month and year) D.R. 11. Total time (years) spent in this occupation DK.

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

FATHER 13. NAME JAMES STONE

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

MOTHER 15. MAIDEN NAME Priscilla West

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bond Co., ILL.

17. INFORMANT (ADDRESS) Hospital Record.

18. BURIAL, CREMATION, OR REMOVAL PLACE Jefferson City DATE May 8 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Shope & Gardner
200 Myrtle St

20. FILED May 8 1940 P. D. Cruise
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 8 1940
22. I HEREBY CERTIFY, That I attended deceased from April 29 1940 to May 8 1940
I last saw him alive on May 8 1940 Death is said to have occurred on the date stated above, at 11:10 a.m.
The principal cause of death and related causes of importance were as follows:

Arteriosclerosis & Chronic Myocarditis
Erysipelas
Date of onset

Other contributory causes of importance: 92L
Frysipelas

Name of operation Clinical Date of
What test confirmed diagnosis? Laboratory 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 , 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 Geo. F. Wood, M. D.
(Signed) (Address) Stateborg #1 Fulton

WHITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
K. 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.

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 *Ferd Dulle*.....

Licensed Embalmer No. *3890*.....

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. 18035-
Registrar's No. _____

Registration District No. 104

Primary Registration District No. 3008

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

1. PLACE OF DEATH:
 (a) County Callaway
 (b) City or town Fulton
(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)

3. (a) PRINT FULL NAME Thomas T. Stone
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased December 3 1860
(Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 2 If less than one day _____ h. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) May 8, 1940 (b) R. N. Crewe
(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 May day 8
 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 _____

Due to _____

Due to _____

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

Major findings:
 Of operations _____

Of autopsy _____

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

23. Signature Geo. F. Wood (M. D. or other) _____

Address Fulton Date signed _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

SUPPLEMENTAL