

1. PLACE OF DEATH:

(a) County: Dunklin  
(b) City or town: Union MO  
(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community end of life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: mo (b) County: Dunklin  
(c) City or town: Campbell mo  
(If outside city or town limits write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME: Robert C. Stephens

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

4. Sex: Male 5. Color or race: White 6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: \_\_\_\_\_ 6. (c) Age of husband or wife if alive: \_\_\_\_\_ years

7. Birth date of deceased: March-8-1868  
(Month) (Day) (Year)

8. AGE: Years: 72 Months: 2 Days: 3 If less than one day: \_\_\_\_\_ hr. 1 min.

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

10. Usual occupation: Farming

11. Industry or business: \_\_\_\_\_

12. Name: uk

13. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name: uk

15. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant: Son in law (Haywood)

(b) Address: Campbell mo

17. (a) Tucker Burial (b) Date thereof: May-12-70  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Tucker Cemetery

18. (a) Signature of funeral director: Landon Funeral Home

(b) Address: Campbell mo 2516

19. (a) May 11-70 (b) Beckman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11  
year 1940 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 11 1940 to May 11 1940

that I last saw him alive on May 9 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis

Due to: \_\_\_\_\_

Due to: 72

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? \_\_\_\_\_

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

23. Signature: John L. Brown (M. D. or other) 1

Address: Campbell Date signed: 5/31/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. **2**

District File Number **640-113**

Date Filed **6/11/40**

**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 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. **18937**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **282**

Primary Registration District No. **5401**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Dunklin**  
(b) City or town **Union 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  
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME

**Robert C. Stephens**

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 **widowed**  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife, if alive

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

8. AGE: Years Months Days If less than one day  
**72 2 3** hr min

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) **May 11 - 1946** (Date received local registrar) (b) **E. W. Dunder** (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 **11** 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

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy

Duration  
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 **John L. Brown** (M. D. or other)  
Address **Campbell** Date signed

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

SUPPLEMENTAL

