

N. E.—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.

S.S.No.—Unknown, if he had one

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

24903
 Do not use this space.

1. PLACE OF DEATH
 (a) County Clay Registration District No. 199
 (b) ~~Township Fishing River~~ Primary Registration District No. 3011 Registered No. 108
 (c) ^{or} City Excelsior Springs, Mo. (d) Street No. Veterans Administration Facility 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. 2 mos. 24 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James W. Stephens
 (a) Residence, No. Beaman, Missouri St. Beaman, Missouri
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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) Mary Elizabeth Stephens

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) February 23, 1891

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	49	4	23	

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

12. BIRTHPLACE (CITY OR TOWN) Boonville 6
 (STATE OR COUNTRY) Missouri

FATHER
 13. NAME John Stephens 0
 14. BIRTHPLACE (CITY OR TOWN) Jamestown 0
 (STATE OR COUNTRY) Missouri

MOTHER
 15. MAIDEN NAME Fronia Stone
 16. BIRTHPLACE (CITY OR TOWN) Carrollton
 (STATE OR COUNTRY) Missouri

17. INFORMANT Hospital Records
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Sadalia, Mo. DATE July 17 1940

19. FUNERAL DIRECTOR (NAME) Claude Prichard 180
 (ADDRESS) Excelsior Springs, Mo.

20. FILED July 17 1940 Mrs. Rea M. Cracker HP
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 16 1940

22. I HEREBY CERTIFY, That I attended deceased from April 22 1940 to July 16 1940
 I last saw him alive on July 16 1940. Death is said to have occurred on the date stated above, at 5:30 P.M.
 The principal cause of death and related causes of importance were as follows:

Nephritis, chronic, with uremia

Other contributory causes of importance:
Post-operative Gastro-enterostomy
Anemia, secondary

Name of operation Gastro-enterostomy Date of 6-14-40
 What test confirmed diagnosis? Examination Was there an autopsy? No
and observation

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? --- 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?
 If so, specify Unknown
 (Signed) W. A. GERMAN, M.D., Clinical Director J. M. D.
 (Address) Veterans Administration
Excelsior Springs, Mo.

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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.....

Robert Ray

working under my personal supervision.

....., Registered Apprentice No. *226*

Signed.....

Marin Hessel

Licensed Embalmer No. *2509*

P. O. Address *Liberty 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.

RECEIVED
District Health Officer No. 8
District File Number *8-8-48*
Date Filed

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24903**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **148**

Primary Registration District No. **3011**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Clay**
(b) City or town **Excelsior Springs**
(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 **James W. 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 **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 **49** Months **4** Days **23** If less than one year, 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) _____ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

(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.

MENTAL CERTIFICATION

20. DATE OF DEATH Month **July** day **16** 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 **Chronic with uremia**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings **Past operative Gastro enterostomy**

Anemia - secondary

Gastro Enterostomy

Cyctic obstruction

22. If death was due to external cause, 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 **W. A. German** (M. D. or other) _____

Address **Excelsior Springs** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

RECEIVED
SEP 6 1940
REGIONAL OFFICE
DARHAMS CITY.

1 2 3 4 5 6 7 8 9 10 11 12