

Registration District No. 862

Primary Registration District No. 6135

State File No. \_\_\_\_\_

Registrar's No. 319

1. PLACE OF DEATH:

(a) County Wagoner  
(b) City or town Cherokee Cherokee township  
(If outside city or town limits, give "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days 2 1/2

3. (a) PRINT FULL NAME ROBERT STEPHENS

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Sara Elizabeth Stephens 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 6 1853  
(Month) (Day) (Year)

8. AGE: Years 87 Months 4 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kalaway Co Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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

12. Name Robert Stephens

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

14. Maiden name Sara Ann Crowson

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

16. (a) Informant Mrs Wesley Nease

(b) Address Cabool, Mo

17. (a) Removal (b) Date thereof 8/31/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fillingim, Mo

18. (a) Signature of funeral director Gaylord V. Elliott

(b) Address Cabool, Mo

19. (a) Aug 30 (b) Mrs Lois Cunningham  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wagoner  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6 miles south Cabool  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 30  
year 1940 hour 10 minute 20 A.M.

21. I hereby certify that I attended the deceased from Aug 14 1940  
that I last saw him alive on Aug 14 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown

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

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

Other conditions 2000 ft  
(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 E. P. Farrell (M. D. or other) \_\_\_\_\_  
Address Cabool Mo Date signed Aug 30 1940

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. 5

District File Number 9401914

Date Filed \_\_\_\_\_

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 Frank E. Wood

Licensed Embalmer No. 4026

P. O. Address Houston, Tex

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.