

FILED MAR 19 1941

Registration District No.

540 Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
 (c) City or town (Rural) Puxico, Mo.
(If outside city or town limits, write "RURAL")
 (d) Street No. Route 3
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Linda L. Stephens

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

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

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

7. Birth date of deceased. Aug. 2 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
4 28 hr. _____ min.

9. Birthplace Stoddard Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

12. Name Dolph Stephens

13. Birthplace Stoddard Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Bessie Durr

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

16. (a) Informant Edna L. McDaniel

(b) Address Dexter, Mo.

17. (a) Burial (b) Date thereof 12/30/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director Blankenship-Strickland

(b) Address Dexter, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 30
 year 1940 hour 1 minute 30 P. M.

21. I hereby certify that I attended the deceased from DEC. 29 1940, to DEC. 29 1940
 that I last saw him alive on DEC. 29 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death BRONCHIAL PNEUMONIA Duration 2 DAYS

Due to _____

Due to _____

Other conditions (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? Y

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

23. Signature R. L. Davis (M. D. or other) MD

Address BLOOMFIELD, MO Date signed 1-6-41

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

3
0
6

1072

RECEIVED

District Health Officer No. 2

District File Number 341-343

Date Filed 3/10/46

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

8376
Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 840
(b) Township Duck Creek Primary Registration District No. 6102
(c) City (d) Street No. 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 Linda L. Stephens

(a) Residence, No. 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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>S</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug-2-1940</u>		
7. AGE	YEARS	MONTHS
		<u>4</u>
		<u>28</u>
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.	
	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)	
	11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Stoddard Co</u>		
FATHER	13. NAME <u>Dolph Stephens</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Stoddard Co</u>	
MOTHER	15. MAIDEN NAME <u>Beessie Clark</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Carroll</u>	
17. INFORMANT (ADDRESS) <u>Edna McDaniel</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Burien Cem</u> DATE <u>12/30</u> 19 <u>40</u>		
19. FUNERAL DIRECTOR (ADDRESS) <u>Blankenship, Street</u>		
20. FILED <u>8-25-</u> 19 <u>41</u> <u>Demaris Bryant</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 30 1940

22. I HEREBY CERTIFY, That I attended deceased from to 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:
Broncho pneumonia

Date of onset

Other contributory causes of importance: 107

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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.....

Was disease or injury in any way related to occupation of deceased? If so, specify.....

(Signed) P. L. Davis M. D.
(Address) Bloomfield Mo

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!

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

