

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **88**

**1. PLACE OF DEATH:**  
 (a) County Adair  
 (b) City or town Kirksville  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: A. S. O. Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 weeks  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME John Robert Stubbs  
 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 Single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Sept. 5 24  
(Month) (Day) (Year)

8. AGE: Years 19 Months 5 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Lumberton N. Carolina  
(City, town, or county) (State or foreign country)

10. Usual occupation Student

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

MOTHER FATHER  
 12. Name Robert S. Stubbs  
 13. Birthplace McLeale S. Carolina  
(City, town, or county) (State or foreign country)  
 14. Maiden name Dora Gibson  
 15. Birthplace Farmersport Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dora Rush

(b) Address 202 Greenwood Blomington Ill

17. (a) Burial (b) Date thereof 3-20-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bloomington Ill

18. (a) Signature of funeral director Doc Riley

(b) Address Kirksville Mo

19. (a) March 20/41 (b) Spencer Freeman  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Illinois (b) County \_\_\_\_\_  
 (c) City or town Bloomington  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 202 Greenwood  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? 2 years.

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month March day 19<sup>th</sup>  
 year 1941 hour 4 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from FEB 20, 1941, to MARCH 19, 1941;  
 that I last saw him alive on MARCH 19, 1941;  
 and that death occurred on the date and hour stated above.

Immediate cause of death SEPTICEMIA

Due to PYELONEPHRITIS

Due to SMALL BOWEL INJURY

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations ✓ Of autopsy \_\_\_\_\_  
 170 99  
**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) Accident; 136

(b) Date of occurrence Sept 1940

(c) Where did injury occur? Near Bloomington Ill.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Automobile accident - N.M.D.  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury Was a Passenger

23. Signature Earl Langley (M. D. or other) 3-20

Address Putzville, Mo Date signed 3-20-41

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

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3  
3

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Dee Riley

Licensed Embalmer No. 4181

P. O. Address Kirksville Md.

**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, fact should be so stated above.**

Registration District No. 1

Primary Registration District No. 1

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Marksville  
(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

John Robert Stuffs

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 8

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 1925 year

7. Birth date of deceased Sept 25 1905  
(Month) (Day) (Year)

|         |           |          |           |                      |
|---------|-----------|----------|-----------|----------------------|
| 8. AGE: | Years     | Months   | Days      | If less than one day |
|         | <u>19</u> | <u>5</u> | <u>24</u> | 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 \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

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) June 9 (b) Spencer L. Freeman  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 19  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration

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? \_\_\_\_\_

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

23. Signature Earl Laughlin (M.D. or other)

Address Marksville Mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

From highway repair. 7-14-41

S-9885 1941

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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.....

....., 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, fact should be so stated above.**