

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

21450

Registration District No. 100

Primary Registration District No. 5279B

State File No. _____

Registrar's No. 27

1. PLACE OF DEATH: Cham
 (a) County Cham
 (b) City or town Kearney Mo Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (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 Fannie Stooksbury
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female / race White / 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Charles Stooksbury 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb 1st 1873
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>10</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
 12. Name Willard Rowland
 13. Birthplace Ray Co Mo (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Cleveland
 15. Birthplace Ray Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Willard Rowland
 (b) Address Subcity 2nd

17. (a) _____ (b) Date thereof Dec 24 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Olivet Cem

18. (a) Signature of funeral director Leonard Ray
 (b) Address Kearney Mo

19. (a) 12/24/40 (b) John Smith
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Clay
 (c) City or town Kearney (If outside city or town limits, write "RURAL")
 (d) Street No. Kearney Street (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 22, 1940
 year 1940 hour 5 minute _____ P.M.

21. I hereby certify that I attended the deceased from Dec. 17th, 1940, to Dec. 22, 1940;
 that I last saw her alive on Dec. 22, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic interstitial nephritis
 Duration 14 yrs.

Due to _____

Due to 1810

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? 1820
 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Patena (M.D. or other) D.O.
 Address Kearney Mo Date signed 12/23/40

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7-11-41

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..... *Leonard Gray*
Licensed Embalmer No. *1677*
P. O. Address. *Kearney* *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.