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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 28073

FILED SEP 11 1941

Registration District No. 2801 — Primary Registration District No. 5280 — Registrar's No. 80

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Rural Chandler
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: County Home Liberty Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: one week (Specify whether years, months or days)
In this community: 5

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Clay
(c) City or town: Nashua
(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: 0

3. (a) PRINT FULL NAME: Robert Stone
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: Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Aug. (Month) 29 (Day) 1859 (Year)
8. AGE: Years 81 Months 11 Days 29 If less than one day hr. min.
9. Birthplace: Platte Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Madison Stone
FATHER 13. Birthplace: (City, town, or county) Ky (State or foreign country)
MOTHER 14. Maiden name: Cockrum
MOTHER 15. Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant: Noah Hart
(b) Address: Chandler Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 30 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Rand Cem - Nashua Mo
18. (a) Signature of funeral director: Chas. Church - Archer Co
(b) Address: Liberty, Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 28 year 1941 hour 6 minute 30 P.M.
21. I hereby certify that I attended the deceased from May 1 1941 to Aug 29 1941 that I last saw him alive on Aug 28 1941 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Aortic Regurgitation ~~Tuberculosis~~ | 5 yrs. |
| Due to: Chronic Alcoholism | 40 yrs. |
| 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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: Burton Mattox (M. D. or other) M.D.
Address: Liberty Mo. Date signed Aug 29 1941

726 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number 4-2-41
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 Edgar Archer

Licensed Embalmer No. 3311

P. O. Address Liberty, Mo.

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

No. 2B
—8-21-41
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 28073

Registration District No. 201 Primary Registration District No. 5280 Registrar's No. 80

**1. PLACE OF DEATH:**

(a) County: Clay

(b) City or town: Country Town
(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 years, months or days)

In this community

**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

3. (a) PRINT FULL NAME: Robert Stone

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: S

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 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Aug 30-41 (Date received by local registrar) (b) Helen Early (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 30 year 1941 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.

| | Duration |
|---|---|
| Immediate cause of death | |
| 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY