DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

38095

State File No.

X26390

Registration District No. DEC 23 1941 184

Primary Registration District No. 5255

Registrar's No. 28

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

1. PLACE OF DEATH:

(a) County: Christian

(b) City or town: Ozark Mo. R.R. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Finley-Mays (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 30 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Christian

(c) City or town: Ozark Rural 22 (If outside city or town limits, write "RURAL")

(d) Street No.: Rural 0 (If rural, give location) 0

(e) Citizen of foreign country? ..... (Yes or No) No

If yes, name country .....

3. (a) PRINT FULL NAME: Willie L. Stockstill

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: M

6. (b) Name of husband or wife: Tabba Stockstill

6. (c) Age of husband or wife if alive: 4-5 years

7. Birth date of deceased: Oct (Month) 12 (Day) 1882 (Year)

8. AGE: Years 59 | Months 0 | Days 21 | If less than one day ..... hr. ..... min.

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

10. Usual occupation: Farmer

11. Industry or business .....

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

MOTHER
14. Maiden name: Lizzie Goodwin
15. Birthplace: L. Kent Lake (City, town, or county) (State or foreign country)

16. (a) Informant: Hiram Stockstill

(b) Address: Ozark Mo. R.R.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 2-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Hughlemphe

18. (a) Signature of funeral director: T. B. Chaffin

(b) Address: Ozark Mo.

19. (a) Dec 1-1941 (Date received local registrar) (b) Loretta Leonard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 3rd year 1941 hour 8 minute 30 a.m.

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

Immediate cause of death: over Dose Carbolic acid poisoning and He died from the effects of it.

Duration

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: B. C. Kilgore Coroner (M. D. or other)

Address: Ozark Mo. Date signed 11/7

170 (Licensed Embalmer's Statement on Reverse Side)

1941

RECEIVED
District Health Officer No. 6,
District File Number 1241-1899
Date Filed DEC 17 1941

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 T. B. Chaffin

Licensed Embalmer No. 2182

P. O. Address Ozark, 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, fact should be so stated above.

No. 2B
—8-21-41
I X29288

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. 38095

Registration District No. 184 Primary Registration District No. 5255 Registrar's No.

1. PLACE OF DEATH:
(a) County: Christian
(b) City or town: Ozark
(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: Wilbur L. Strickstil
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: M
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: 49 years
7. Birth date of deceased: Oct. 12, 1882 (Month) (Day) (Year)
8. AGE: Years 59 Months 0 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
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 3 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: Acute dose Carbolic	
Due to: acid Solution to be	
Due to: Died from the effects	
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

Suicide 1637