

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

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town East Prairie, MO  
(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.....  
In this community 17 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO County Missouri  
(c) City or town East Prairie, MO  
(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 Albert H. Stone  
3. (b) If veteran, name war..... 3. (c) Social Security No. ....

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 9th day Jan  
year 1942 hour..... minute 10 a.m.

4. Sex Male 5. Color or race W  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased June 1926  
(Month) (Day) (Year)

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.

8. AGE: Years 80 Months 7 Days 2 If less than one day hr. .... min.

Immediate cause of death Cerebral apoplexy Duration.....

9. Birthplace Francisville Ind. 1  
(City, town, or county) (State or foreign country)

Due to myocarditis

10. Usual occupation Carpenter

Due to arterio-sclerosis & Nephritis

11. Industry or business Woodsman

Other conditions..... (Include pregnancy within 8 months of death)

12. Name unknown

Major findings: Of operations 830

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

Of autopsy.....

14. Maiden name unknown

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

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs E. D. Clark

22. If death was due to external causes, fill in the following:

(b) Address East Prairie, Mo Rt

(a) Accident, suicide, or homicide (specify).....

17. (a) Burial (b) Date thereof Jan. 10 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence.....

(c) Place: burial or cremation M. O. W. Home

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

18. (a) Signature of funeral director Mrs. S. Shelby

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

(b) Address East Prairie, Mo

23. Signature Beulah H. Hittler (M. D. or other) M.D.  
Address East Prairie, Mo Date signed 1/17/42

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 *not*  
*Embalmed* \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed

*Travis Shelby*

Licensed Embalmer No.

*2926*

P. O. Address

*East Game M*

**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.**

FILED FEB 18 1942

Registration District No. *667*

Primary Registration District No. *4334*

Registrar's No. *1*

1. PLACE OF DEATH:

(a) County *Miss Co*  
(b) City or town *East Prairie Mo*  
(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. *10 years*  
In this community *10 years* (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Miss*  
(c) City or town *East Prairie*  
(If outside city or town limits, write "RURAL")  
(d) Street No. *0*  
(If rural, give location)  
(e) Citizen of foreign country? *0* (Yes or No)  
If yes, name country *0*

3. (a) PRINT FULL NAME *ALBERT H. STONE*

3. (b) If veteran, name war *1* 3. (c) Social Security No. *0*

4. Sex *Male* 5. Color *White* 6. (a) Single, widowed, married, divorced *Single*

6. (b) Name of husband or wife *0* 6. (c) Age of husband or wife if alive *0* years

7. Birth date of deceased *June 7 - 1861*  
(Month) (Day) (Year)

8. AGE: Years *80* Months *7* Days *2* If less than one day *0* min.

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

10. Usual occupation *Laborer*

11. Industry or business *0*

MOTHER FATHER

12. Name *Unknown*  
13. Birthplace *Unknown* 9  
(City, town, or county) (State or foreign country)  
14. Maiden name *Unknown*  
15. Birthplace *Unknown* 9  
(City, town, or county) (State or foreign country)

16. (a) Informant *Wm Ed - Clock*  
(b) Address *East Prairie Mo*

17. (a) Burial, cremation, or removal *0* (b) Date thereof *Jan 10 - 1942*  
(Month) (Day) (Year)

(c) Place: burial or cremation *0*

18. (a) Signature of funeral director *J. W. Shely*  
(b) Address *East Prairie Mo*

19. (a) Date received local registrar *Feb 11-42* (b) Registrar's signature *Max U. M. Hodge*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *9* day *Jan*  
year *1942* hour *0* minute *0* M.

21. I hereby certify that I attended the deceased from *0*, 19*42*, to *0*, 19*42*, that I last saw him *0* alive on *0*, 19*42*, and that death occurred on the date and hour stated above.

Immediate cause of death *Cerebral apoplexy*  
Due to *Arterio Sclerosis*  
Due to *rephritis myocarditis*  
Other conditions *0*  
(Include pregnancy within 3 months of death)

Duration *4 days*

Major findings: Of operations *0*  
Of autopsy *1316*

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) *0*  
(b) Date of occurrence *0*  
(c) Where did injury occur? *0*  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? *0*

While at work? *0* (Specify type of place) (2) Means of injury *0*

23. Signature *Dr. Sw. M. Hodge* (M.D. or other) *0*  
Address *0* Date signed *0*

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

FEB 13 1942

*Handwritten notes, possibly "No. 127"*

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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 *Thomas Shelby*

Licensed Embalmer No. *2726*

P. O. Address *East Orange, N.J.*

**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.**