

Registration District No. 384

Primary Registration District No. 4227

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Newell
(b) City or town West Plains mo
(c) Name of hospital or institution: West Plains Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 yrs (Specify whether years, months or days)
In this community 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Newell
(c) City or town West Plains mo
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Chas. H. Stephens

3. (b) If veteran. name war _____ 3. (c) Social Security No. _____

4. Sex mo 5. Color or race w 6. (a) Single, widowed, married, divorced. 1m
6. (b) Name of husband or wife. Sarah Stephens 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased 4-18-71 (Month) (Day) (Year)

8. AGE: Years 70 Months 9 Days 14 If less than one day hr. _____ min _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name W. H. Stephens
13. Birthplace Franklin Co, Ky (City, town, or county) (State or foreign country)
14. Maiden name Anna Stephens
15. Birthplace Lynn Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nellie Kirby
(b) Address Lynn Co Mo

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof 1-16-42 (Month) (Day) (Year)
(c) Place: burial or cremation Local Burial

18. (a) Signature of funeral director West Plains mo
(b) Address West Plains mo

19. (a) Date received local registrar: Jan 28-1942 (Registrar's signature) Chas. H. Stephens

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 15 year 1942 hour 5 minutes 35 P. M.

21. I hereby certify that I attended the deceased from 1/13 1942 to 1/15 1942 that I last saw him alive on 1/15 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism Duration 1 hr
Due to _____
Due to Cystitis 2 days

Other conditions 1/10 (Include pregnancy within 3 months of death)

Major findings: hypertrophied prostate
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? _____

23. Signature Walter H. Hunter (M. D. or other) D. M. D.
Address West Plains Date signed 1/26/42

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

16
1

RECEIVED

District Health Officer No. 5.

District File Number 442363.

Date Filed 2-20-42

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.....

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

Signed D. D. Robert

Licensed Embalmer No. 3432

P. O. Address West Hanover

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.