

S. No. 2
4-5-42
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12829

State File No. _____

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

X32875

APR 28 1943

Registration District No. **318**

Primary Registration District No. _____

Registrar's No. **360**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **Saint Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Barnes Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8 hours**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Oklahoma** (b) County _____

(c) City or town **Grove**
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Bertha Stephenson**

3. (b) If veteran, name war **--**

3. (c) Social Security No. **--**

4. Sex **Female** / 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife **--**

6. (c) Age of husband or wife if alive **--** years

7. Birth date of deceased **Sept. 19, 1901**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
41	6	27	_____ hr. _____ min.

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

10. Usual occupation **At home**

11. Industry or business _____

MOTHER FATHER

12. Name **R. R. Holt**

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

14. Maiden name **Rachael Parker**

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

16. (a) Informant **Willard Holt**

(b) Address **Hamilton Hotel**

17. (a) **Removal** (b) Date thereof **4/17/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Grove, Okla.**

18. (a) Signature of funeral director **Craig Mortuary**

(b) Address **4468 Washington**

19. (a) **APR 17 1943** **J. F. Bradack**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **16**
year **1943** hour **8** minute **50** A.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.

Immediate cause of death _____

Brain Tumor Recurred

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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 **3**

23. Signature **Alfred Henry** (M. D. or other)

Address **St. Louis** Date signed **4/17/43**

846

2910

JUN 18 1963

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 *Philip M. Leary*

Licensed Embalmer No. 3281

P. O. Address 4468 Washington Blvd.

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.