

No. 3  
5-42  
5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24518

FILED JUL 30 1943

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 210

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Lucy Lee Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 hrs  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard  
(c) City or town Malden, Rural Route 2  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29  
year 1943 hour 1 minute 25P M.

21. I hereby certify that I attended the deceased from 6/29  
to 6-29, 1943  
that I last saw him alive on 6/27, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Acute nephritis ✓ 1 wk?

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 sta-  
tistically.

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)  
Mean of injury \_\_\_\_\_

23. Signature D. Parker (M. D. or other) \_\_\_\_\_  
Address Poplar Bluff, Mo Date signed 7/3/43

3. (a) PRINT FULL NAME William Robert Stone

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 Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 21 1935  
(Month) (Day) (Year)

8. AGE: Years 8 Months 4 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Schoolboy

11. Industry or business \_\_\_\_\_

12. Name James Stone

13. Birthplace Polk County Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Louisa Vantrease

15. Birthplace Hamilton County Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. and Mrs. James Stone

(b) Address Malden, Missouri Route 2

17. (a) Burial (b) Date thereof 6-30-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden, Mo.

18. (a) Signature of funeral director H. L. Craig

(b) Address Malden, Mo

19. (a) 7-6-43 (b) Belle Kinne  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

92

RECEIVED

District Health Office No. 2,

District File Number 742-968

Date Filed 2-23-73

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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 H. L. Craig

Licensed Embalmer No. 4302

P. O. Address Malden

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.

Registration District No. 43 Primary Registration District No. 3007

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Lucy Lee Hosp.  
(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 \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Wm 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: Feb 2 (Month) 1943 (Day) 1943 (Year)

8. AGE: 8 Years 4 Months 4 Days mo. (Unless than one day min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death: acute nephritis Duration \_\_\_\_\_

Due to acute tonsillitis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 130

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)

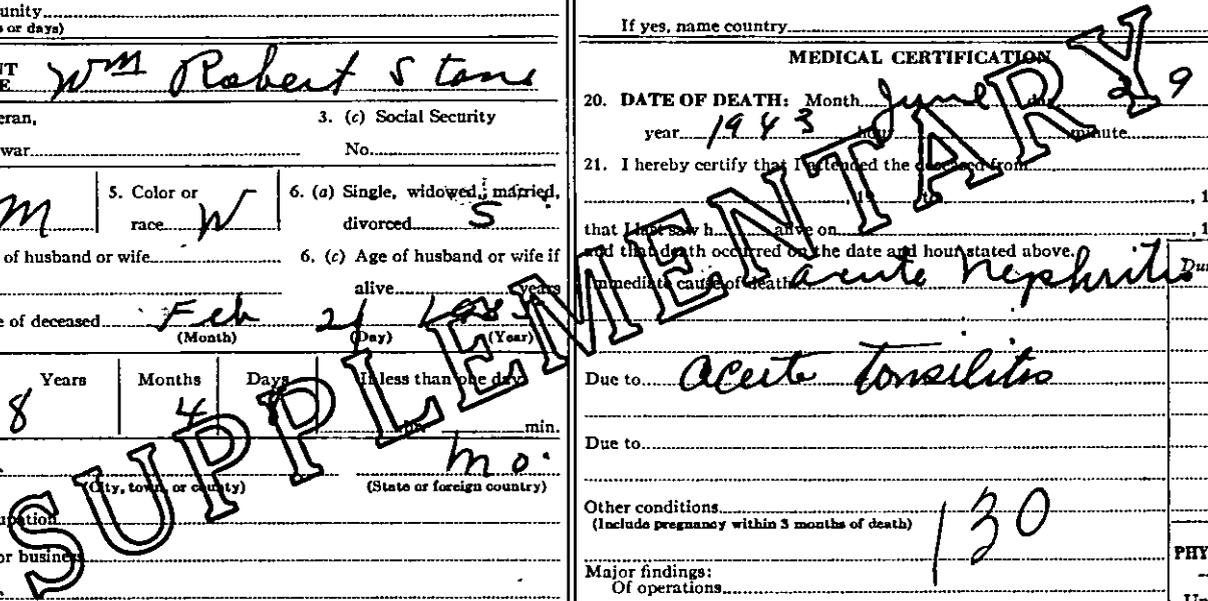
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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



S. 24518