S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 14 1944

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 2625

Registration District No. 94 — Primary Registration District No. 5345 — Registrar's No.

1. PLACE OF DEATH:
(a) County: Dade
(b) City or town: Rural Sac Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5 mi. N. of Greenfield
(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: Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Dade
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: 5 mi. N. of Greenfield
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Maggie May Stump

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: George

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

7. Birth date of deceased: November (Month) 7 (Day) 1889 (Year)

8. AGE: Years 54 Months 0 Days 19 If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housewife

11. Industry or business: Home

MOTHER FATHER

12. Name: Jack Brown

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

14. Maiden name: Florence Rowan

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

16. (a) Informant: George Stump
(b) Address: Greenfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-28-43. (Month) (Day) (Year)
(c) Place: burial or cremation: Greenfield Cemetery

18. (a) Signature of funeral director: Ward Funeral Home
(b) Address: Greenfield, Mo.

19. (a) 11-30-43 (Date received local registrar) (b) Kyle Kirby (Registrar's signature)

1343

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: November day: 26 year: 1943 hour: 8:40 P.M. minute: ____ M.

21. I hereby certify that I attended the deceased from 11-24-, 1943 to 11-26-, 1943 that I last saw him alive on 11-26-26-, 1943 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Diabetic Coma | |
| Due to: | |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): Lobar Pneumonic | |

Major findings:
Of operations: 61
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: 0

23. Signature: J. D. Combs (M. D. or other)
Address: Lockwood Mo Date signed: 11-27-43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number 244-137
Date Filed FEB 11 1944

## 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 Sam C. Sensenney Jr

Licensed Embalmer No. 4099

P. O. Address Greenfield 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.**