DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 24 1944

Registration District No. 374

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8663

Primary Registration District No. 6273

Registrar's No.

1. PLACE OF DEATH:

(a) County: Worth

(b) City or town: Grant City Mo. Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Fletchall
East of Grant City
(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: Entire Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Worth 113

(c) City or town: Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. Grant City Mo.
(If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: Orra Jane Stabe

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: F

5. Color or race: W

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

6. (b) Name of husband or wife: Ollie Stabe

6. (c) Age of husband or wife if alive: 62 years

7. Birth date of deceased: April (Month) 1 (Day) 1881 (Year)

8. AGE: Years 62 | Months 8 | Days 23 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housewife

11. Industry or business:

MOTHER FATHER

12. Name: Robert Stone Willhite

13. Birthplace: Worth County Mo (City, town, or county) (State or foreign country)

14. Maiden name: Elizabeth Ellen Vahatta

15. Birthplace: Unknown (City, town, or county) Ohio (State or foreign country)

16. (a) Informant: Ollie Stabe

(b) Address: Grant City Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 26 1943 (Month) (Day) (Year)

(c) Place: burial or cremation: Grant City Cemetery

18. (a) Signature of funeral director: John Andrews Jr

(b) Address: Grant City Mo

19. (a) 1-20-44 (Date received local registrar) (b) Arlene Scott (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 24 day Dec year 1943 hour 6 o'clock P. M.

21. I hereby certify that I attended the deceased from Jan 1 1940 to Dec 24 1943 that I last saw her alive on Dec 24 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Sarcoma	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED	
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? (Specify type of place)

While at work? (e) Means of injury: 0

23. Signature: John Andrews M.D.

Address: Grant City Date signed 1-15-44

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

John Andrews Jr....., Registered Apprentice No.....

working under my personal supervision.

Signed John Andrews Jr

Licensed Embalmer No. 4321

P. O. Address Grant City M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 374   Primary Registration District No. 6273   Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Worth
(b) City or town Rural Fletchall Twp (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

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

3. (a) PRINT FULL NAME Orra Jane Stake
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive 1 88 years
7. Birth date of deceased April (Month) 1 (Day) 1882 (Year)
8. AGE: Years 62 Months 8 Days 23 If less than one day ... hr. ... min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24 year 1944 hour minute M.
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.

	Duration
Immediate cause of death ~~Sarcoma~~	
Due to Carcinoma of Bowels	
Due to	
Other conditions (Include pregnancy within 3 months of death)	46
Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED	PHYSICIAN — Underline the cause to which death should be charged statistically.
Of autopsy	

22. If death was due to external causes, fill in the following: No
(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
23. Signature Dr John Anderson (M. D. or other)
Address Grant City   Date signed 3/16/45

8403