

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11379

FILED MAR 26 1945
Registration District No. 175

Primary Registration District No. 4280

State File No. _____

Registrar's No. 17

1. PLACE OF DEATH

(a) County Lawrence

(b) City or town Stotts City Mo.
(If outside city or town limits, write "RURAL")

(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 _____)
In this community _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lawrence 55

(c) City or town Stotts City Mo.
(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 Robert F. Stotts

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 Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased Dec 8 1857
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

86 1 24 hr. min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Ann Stotts

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

14. Maiden name Williamina Moss

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

16. (a) Informant Mrs. Robert Stotts

(b) Address Stotts City Mo.

17. (a) _____ (b) Date thereof Feb 5 - 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moss Cemetery

18. (a) Signature of funeral director Mr. Russell G. Pince

(b) Address Pince City Mo.

19. (a) Feb 2 1945 (b) _____ (c) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1 at
year 1945 hour 8:50 minute PM

21. I hereby certify that I attended the deceased from Jan 31 1944 to Feb 1 1945
that I last saw him alive on Jan 31 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia
Due to Myocardial failure
Due to Chronic hypertrophic atherosclerosis (deformans) several years

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

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Kenneth Glover (M. D. or other) _____
Address W. Vernon, Mo. Date signed 2/2/45

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

RECEIVED

District Health Officer No. 6,

District File Number 344-376

Date Filed MAR 16 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 me

....., Registered Apprentice No. 6
working under my personal supervision.

Signed Wm. H. Hensell

Licensed Embalmer No. 9512

P. O. Address Peoria City, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. _____

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Stotts city
(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 all of life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert F. Stotts

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 m

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

7. Birth date of deceased Dec 8 1915
(Month) (Day) (Year)

8. AGE: Years 86 Months _____ Days _____ (Unless than one day) min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 Feb day _____
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death hypostatic pneumonia
(lobar) Duration _____

Due to _____

Due to _____

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

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUEST
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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

11379