

FILED MAY 8 1944

Registration District No. 321

Primary Registration District No. 5461

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Rogersville, Rural, Washington  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39  
(c) City or town Rogersville, Rural, Washington  
(If outside city or town limits, write "RURAL") T.S.  
(d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sylvia Stump

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 Married  
6. (b) Name of husband or wife Melvin 6. (c) Age of husband or wife if alive 75 years  
7. Birth date of deceased Sept. 3 1878  
(Month) (Day) (Year)

8. AGE: Years 65 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name B. F. Slattler

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

14. Maiden name Amanda Corn

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

16. (a) Informant Mr. Melvin Stump

(b) Address Rogersville, Mo. R#2

17. (a) Burial (b) Date thereof Mar 17-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Leon, Iowa

18. (a) Signature of funeral director Kelley-Ferrell

(b) Address Rogersville, Mo.

19. (a) Mar 13-44 (b) Mrs. Frank Smith  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11  
year 1944 hour 10 minute 45 P. M.

21. I hereby certify that I attended the deceased from Jan  
1944 to Mar 11 19 44  
that I last saw her alive on Mar 11 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy

Due to Hypertension

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)

Signature Eugene Munier (M. D. or other)

Address Rogersville Mo Date signed 3-13-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

900

RECEIVED

Greene County Health Office,

County File Number 44-5-31

Date Filed 5-6-44

MAR 29 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 H. K. Kelley  
Licensed Embalmer No. 3334  
P. O. Address 3934 Seymour

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.