S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 5 1945
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39833

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11161

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phillips Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days (Specify whether years, months or days)
In this community 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ohio
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 1 4 19
(d) Street No. 801 Clarkston Place (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ERNEST STUBBLEFIELD
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male 2
5. Color or race Negro
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years abt 46 Months — Days — If less than one day hr. min.
9. Birthplace Marianna, Arkansas (City, town, or county) (State or foreign country)
10. Usual occupation Carpenter
11. Industry or business
FATHER 12. Name Morgan Stubblefield
FATHER 13. Birthplace Miss. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Unknown
MOTHER 15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Oral Stubblefield
(b) Address Pine St. Y. M. C. A.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Marianna, Arkansas
18. (a) Signature of funeral director
(b) Address 1221 N. Grand Blvd.
19. (a) DEC 28 1944 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 26, year 1944 hour 8 minute 50 P. M.
21. I hereby certify that I attended the deceased from December 24, 1944 to December 26, 1944; that I last saw him alive on December 26, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage with right hemiplegia	4 days
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 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
23. Signature Alva Moore (M. D. or other)
Address 2601 Thurston Date signed 12/28/44

(Licensed Embalmer's Statement on Reverse Side)

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 William C. McDowell, Registered Apprentice No.....,
working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2114

P. O. Address.....

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.