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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 17 1945
Registration District No. 87

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5974
State File No. _____
Registrar's No. _____

Primary Registration District No. 4150

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

1. PLACE OF DEATH:
(a) County Crawford
(b) City or town Bourbon
(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 Crawford 29
(c) City or town Leasburg
(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 IDA STEPHENS
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 12
year 1944 hour 12 minute 20 P.M.

4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from Oct. 7, 1944 to Dec. 12, 1944
that I last saw her alive on Dec. 12, 1944
and that death occurred on the date and hour stated above.
Immediate cause of death Fracture of right hip. Duration _____

7. Birth date of deceased May - 14 - 1864
(Month) (Day) (Year)
8. AGE: Years 80 Months 6 Days 28
If less than one day _____ hr. _____ min.

Due to _____
Due to _____

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

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

10. Usual occupation Housewife

Major findings:
Of operations _____
Of autopsy _____

11. Industry or business _____

12. Name Like Parsons

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant Santa Hunter

(b) Address Leasburg Mo

17. (a) Burial (b) Date thereof 12-15-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leasburg

18. (a) Signature of funeral director Elbert Long
(b) Address Bourbon Mo

19. (a) 12-14-44 (b) H. F. Swain M.D.
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident 02
(b) Date of occurrence Oct. 10 - 1944
(c) Where did injury occur her home Leasburg Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Leasburg, Crawford Mo
While at work? _____ (Specify type of place)
(a) Means of injury _____
23. Signature William D. French (M. D. or other) _____
Address Rolla Mo Date signed 12/12/44

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5.

District File Number 245-100

Date Filed 2-14-45

FEB 26 1945

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 Elbert Long

Licensed Embalmer No. 3804

P. O. Address Bowling 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. MarchRegistration District No. 87Primary Registration District No. 4150

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town Bourbon
(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 days3. (a) PRINT
FULL NAME Ida Stephens3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex F5. Color or
race w6. (a) Single, widowed, married,
divorced w

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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) _____

(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)

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 Dec day 12
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.Immediate cause of death Fracture of right hip duration 2Due to (Accident) Fall

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 sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident(b) Date of occurrence 12-7-44(c) Where did injury occur? Home Seaburg, Mo.
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?
HomeWhile at work? _____ (Specify type of place)
(c) Means of injury _____23. Signature Walla (M. D. or other) _____Address _____ Date signed 9/14/45

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

MOTHER FATHER

SUPPLEMENTARY

5974