V. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 9 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16619

Registration District No. 10

Primary Registration District No. 4127

Registrar's No. 40

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

1. PLACE OF DEATH:
(a) County Clark
(b) City or town Luray
(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 life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Clark
(c) City or town Luray
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Estey Ross Stevens
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Elizabeth Stevens
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased April (Month) 3 (Day) 1881 (Year)

8. AGE: Years 64 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Luray (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Farming
11. Industry or business
FATHER
12. Name John Stevens
13. Birthplace Mo (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Josephine Dochterman
15. Birthplace Mo (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Elizabeth Stevens
(b) Address Luray Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 21-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Combs Co. Luray Mo.
18. (a) Signature of funeral director Tutting Und.
(b) Address Luray Mo.
19. (a) 5-22-45 (Date received local registrar) (b) P. S. Borton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19
year 1945 hour 6 minute 55 P.M.
21. I hereby certify that I attended the deceased from 5-18- 1945, to 5-19- 1945
that I last saw him alive on 5-19- 1945
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 S H Channing (M. D. or other) DO
Address Kahoka Mo. Date signed 5-21-45

1273 (Licensed Embalmer's Statement on Reverse Side)

SEP 1 5 1950

RECEIVED
District Health Officer No. 10
District File Number 6-45-892
Date Filed JUN 7 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 Oler L. Lutting

Licensed Embalmer No. 2965

P. O. Address Luray 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.