S. No. 2
M—2-43
. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16956

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 410

1. PLACE OF DEATH:

(a) County: Greene

(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Medical Arts Building
(If not in hospital or institution, write street number or location) 3

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: C. Webster

(c) City or town: Seymour 112
(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: Charles Philip Stokes

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Male M

5. Color or race: White

6. (a) Single, widowed, married, divorced: Child

6. (b) Name of husband or wife: None

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

7. Birth date of deceased: Jan. (Month) 25, (Day) 1944 (Year)

8. AGE: Years 1 Months 3 Days 23 If less than one day ..... hr. ..... min.

9. Birthplace: Seymour (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Child

11. Industry or business .....

MOTHER' FATHER

12. Name: Otto Howard Stokes

13. Birthplace: Webster Co. (City, town, or county) Missouri (State or foreign country)

14. Maiden name: Cora Don Johns

15. Birthplace: Webster Co. (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Mr. + Mrs. Otto Stokes

(b) Address: Seymour, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-20-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Marshfield Cem.

18. (a) Signature of funeral director: Oc Gainey

(b) Address: Marshfield Mo.

19. (a) 5-19-45 (Date received local registrar) (b) B W Hardy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 18 year 1945 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from 5-11-45, 19..... to 5-11-45, 19.....; that I last saw him alive on 5-11-45, 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Alkalosis	2d
Due to: Acute infectious enteritis	1wk
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 93e	
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: 0

23. Signature: Lestar Busick (M. D. or other)

Address: Springfield Mo. Date signed 5-18-45

984 (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 ——, Registered Apprentice No. ——, working under my personal supervision.

Signed Rex Rainey

Licensed Embalmer No. 3312

P. O. Address Marshfield, 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.