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FILED MAY 16 1945

Registration District No. **132**

Primary Registration District No. **3021**

Registrar's No. **307**

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

10-11-10

1. PLACE OF DEATH:

(a) County Grundy

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

(c) Name of hospital or institution:
612 WEST 18TH
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 6 MONTHS (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Grundy **40**

(c) City or town IRENEXON **1**
(If outside city or town limits, write "RURAL") **2**

(d) Street No. 612 WEST 18TH
(If rural, give location)

(e) Citizen of foreign country? No **0** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ALICE M STEVENSON

3. (b) If veteran, name war _____

3. (c) Social Security No. NINE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 25TH
year 1945 hour 4:00 minute 9 M.

21. I hereby certify that I attended the deceased from 11-11-1944 to 4-25-1945
that I last saw her alive on 4-18- and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race BLACK

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: May 15 1875
(Month) (Day) (Year)

Immediate cause of death Pneumonia ✓

Due to Paralysis

Due to Hypertension + apoplexy

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

Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

8. AGE: Years 69 Months 11 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Clay County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEKEEPER

11. Industry or business HOME

12. Name Charlie Stevenson

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

14. Maiden name Rachel Stearns

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

16. (a) Informant Archie Stearns

(b) Address Ironton Mo

17. (a) burial (b) Date thereof April, 28, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maude Home, Ironton, Mo

18. (a) Signature of funeral director Royce A. Adams

(b) Address Ironton Mo

19. (a) 4-27-45 (b) L. S. Roberts
(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) _____

(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 M. A. Jones (M. D. or other) MD

Address Ironton Mo Date signed 4-26-45

13-31

RECEIVED
District Health Officer No. 14
District File Number
Date Filed

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.

My self

Signed *Fayme A. Adams*
Licensed Embalmer No. *3424*
P. O. Address *Denton, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 132

Primary Registration District No. 3021

1. PLACE OF DEATH:
(a) County Grundy
(b) City or town Wentworth
(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

3. (a) PRINT FULL NAME Alice M. Stevenson
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased May 15
(Month) (Day) (Year)

8. AGE: Years 69 Months _____ Days _____ If less than one day _____ hr. _____ 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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 _____ Day 25
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to Bronchial Pneumonia
Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

NATIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature W. A. Jones (M. D. or other) MD
Address _____ Date signed _____

SUPPLEMENTARY

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

17003