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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23921

State File No.

FILED AUG 14 1945

Registration District No. 120

Primary Registration District No. 5444

Registrar's No. 65

1. PLACE OF DEATH

(a) County Greene - Athens Twp
(b) City or town (Rural) Albany Mo
(If outside city or town limits, write "RURAL" with name of township)
(c) Name of hospital or institution: County Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 years (Specify whether years, months or days)
In this community "

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Greene
(c) City or town Albany Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 17th - Athens
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country "

3. (a) PRINT FULL NAME Mr. Clyde Stockton

3. (b) If veteran, name war V 3. (c) Social Security No. NONE

4. Sex M 5. Color or race " 6. (a) Single, widowed, married, divorced S.I.P.

6. (b) Name of husband or wife NONE 6. (c) Age of husband or wife if alive 8 years

7. Birth date of deceased Aug 8 1879
(Month) (Day) (Year)

8. AGE: Years 65 Months 10 Days 12 If less than one day hr. min.

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

10. Usual occupation laborer

11. Industry or business "

12. Name W. Alexander Stockton

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

14. Maiden name "

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

16. (a) Informant County Hospital Physician

(b) Address Albany Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/45 (Month) (Day) (Year)

(c) Place of burial or cremation Stanton Mo

18. (a) Signature of funeral director Patricia Phillips

(b) Address Stanton Mo

19. July 23/1945 (Date received local registrar) (b) Harriet M. Drake (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20 year 1945 hour 10 minute A M.

21. I hereby certify that I attended the deceased from from 19 1945 to July 20 1945 that I last saw him alive on July 20 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of stomach

Due to "

Due to "

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

Major findings: Of operations "

Of autopsy "

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 J. Y. Bony (M. D. or other)

Address Albany Mo Date signed 7/21/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23921

Registration District No. 120

Primary Registration District No. 544x

Registrar's No. 65

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

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Paris
(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 Clyde Stockton

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased Aug 8 (Month) (Day) (Year)

8. AGE: Years 65 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 _____

MOTHER FATHER

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. Oct 1-1945 (Date received local registrar) Thomas M. Tinkler (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 _____ Year 1945 hour _____ minute _____ M.

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

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other)

Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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