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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED SEP 12 1945

State File No. 27433

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 640

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: O'Reilly Gen Hosp, Springfield, Missouri
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 hours (Specify whether years, months or days)
In this community 21 hours

2. USUAL RESIDENCE OF DECEASED:

(a) State Alabama (b) County JACKSON

(c) City or town Dutton
(If outside city or town limits, write "RURAL")

(d) Street No. Route #1
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME L. D. Stone

3. (b) If veteran, name war World War II

3. (c) Social Security No. Unknown

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased September (Month) 24 (Day) 1920 (Year)

8. AGE: Years 24 Months 10 Days 21 If less than one day 6 hr. 10 min.

9. Birthplace Jackson County, Dutton, Alabama
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name James Allen Stone

13. Birthplace Hart County, Georgia
(City, town, or county) (State or foreign country)

14. Maiden name Ann Bell

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

16. (a) Informant O'Reilly General Hospital

(b) Address Springfield, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 16 Aug 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Scottsboro, Alabama

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 8-16-45 (Date received local registrar) (b) & W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15 year 1945 hour 6 minute 10 A. M.

21. I hereby certify that I attended the deceased from 9:30 PM, 14 Aug 1945, to 6:10 AM, 15 Aug 1945; that I last saw him alive on 6:10 AM, 15 August 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Subdural hematoma, right	21 hrs
Due to Fracture of skull, right temporal	21 hrs
Due to UNKNOWN	
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 statistically.

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

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 14 August 1945

(c) Where did injury occur? Springfield, Greene, Missouri (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Specify type of place)

While at work? No (e) Means of injury UNKNOWN

23. Signature Morris Greenberg (M.D. or other) Capt MC

Address O'Reilly General Hosp. Date signed Aug 16 1945

984 (Licensed Embalmer's Statement on Reverse Side)

MAY 17 19

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 L. A. Roof

Licensed Embalmer No. 3048

P. O. Address Springfield 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.