

FILED AUG 18 1945 STANDARD CERTIFICATE OF DEATH

State File No. 27860

Registration District No. 205

Primary Registration District No. 5740

Registrar's No. 7

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

1. PLACE OF DEATH:

(a) County Mason
(b) City or town "Rural" Lingo Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
9 miles S.W. of New Cambria
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Rife
years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mason
(c) City or town New Cambria "Rural"
(If outside city or town limits, write "RURAL")
(d) Street No. 9 miles S.W. of New Cambria
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No?)
If yes, name country _____

3. (a) PRINT FULL NAME ALEXANDER WALTER STILL

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 Widowed

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

7. Birth date of deceased October 1 1868
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 12 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Joseph M. Still

13. Birthplace Montgomery Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Stevenson

15. Birthplace Montgomery Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Still

(b) Address Marceline, Mo.

17. (a) Burial (b) Date thereof July 14 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation High Hill Cemetery

18. (a) Signature of funeral director A. H. Hilliard

(b) Address New Cambria, Mo.

19. (a) July 13, 1945 (b) Almanon Hilliard
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
year 1945 hour 11 P.M. minute _____ M. _____

21. I hereby certify that I attended the deceased from May 6th 1945 to July 12 1945
that I last saw him alive on July 12 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Syphilis Duration 1 yr

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) no

Major findings: Of operations _____ Of autopsy no

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 C. O. West (M. D. or other) _____
Address New Cambria, Mo. Date signed July 12 45

1050

RECEIVED

District Health Officer No. 10

District File Number 8-45-1229

Date Filed AUG-1-6-1945

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 *H. J. Gilliland*

Licensed Embalmer No. 4019

P. O. Address *New Cambria, 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.