

FILED SEP 20 1945

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 292

Primary Registration District No. 4434

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ralls
(b) City or town Center
(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 25 years
years, months or days)

3. (a) PRINT FULL NAME Robert A. Stone

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 Married

6. (b) Name of husband or wife Florence Stone 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Aug 7 1870
(Month) (Day) (Year)

8. AGE: Years 75 Months 10 If less than one day
hr. min.

9. Birthplace Shelby Co - Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Own Farm

12. Name John A. Stone

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

14. Maiden name Unknown

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

16. (a) Informant Wm N. Stone

(b) Address Oklahoma City, Okla

17. (a) Burial (b) Date thereof Aug 21 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Dale Cemetery

18. (a) Signature of funeral director Headman

(b) Address Center Mo

19. (a) Aug 22 1945 (b) Mrs. Earl Perkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ralls 87
(c) City or town Center
(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 Aug day 17
year 1945 hour 2 minute 45p M.

21. I hereby certify that I attended the deceased from June 14
1944 to Aug 17 1945
that I last saw him alive on Aug 17
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Myocarditis (Acute) 2 days

Due to Myocarditis Chronic 14 mo's

Due to Arteriosclerosis 3 yrs

Other conditions None Known

(Include pregnancy within 3 months of death)

Major findings: None

Of operations None

Of autopsy None

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. H. Brooks (M. D. or other) DO

Address Center, Mo Date signed 8-21-45

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

MOTHER FATHER

1135

RECEIVED

District Health Officer No. 10

District File Number 9-45-1432

Date Filed SEP-17-1945

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. 4263, working under my personal supervision.

Signed

Wes P. Hume

Licensed Embalmer No.

4263

P. O. Address

Center

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.