

No. 2  
2-43  
17-39  
X35697

FILED NOV 13 1945

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 845

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

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:  
**709 N. BROADWAY**  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE** **39**

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

(d) Street No. **709 N. Broadway** **6**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No) **Ⓧ**  
If yes, name country \_\_\_\_\_

3. (a) PRINT **ANNA L. STEPHENS**  
FULL NAME

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE**

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

6. (b) Name of husband or wife **UNK.**

6. (c) Age of husband or wife if alive **Dec** years **18** 1877

7. Birth date of deceased **SEPT.** 18, 1877  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<b>68</b>	<b>17</b>	<b>1</b>	<b>1</b>	hr. min.

9. Birthplace **VANDALIA ILL.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE WIFE**

11. Industry or business **AT HOME**

12. Name **Unknown**

13. Birthplace **Unknown ILL. A**  
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown ILL. A**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ralph L. Stephens**

(b) Address **SPRINGFIELD MO.**

17. (a) **Burial** (b) Date thereof **10-22-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MAPLE PARK Cem.**

18. (a) Signature of funeral director **J.W. Hughes & Co**

(b) Address **SPRINGFIELD MO.**

19. (a) **10-20-45** (b) **Dr W. H. Handley**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **19**  
year **1945** hour **4** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **Oct. 7** 1945 to **Oct. 19** 1945;  
that I last saw her alive on **Oct. 19** 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Embolus** Duration \_\_\_\_\_

Due to **lying in bed because of heart injury suffered on Oct 21/45**

Due to **falling down Church steps**

Other conditions **Arterio-sclerotic heart disease**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**ADDITIONAL 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) **1.33** ✓

(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 **T. Terrell** (M. D. or other) \_\_\_\_\_

Address **Springfield, Mo.** Date signed \_\_\_\_\_

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NOV 19 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

*Ogle Stone Jr.*

Licensed Embalmer No.

*4126*

P. O. Address

*Springfield*

**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.**

*X*

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Nov  
Registrar's No. 845

Registration District No. 128 Primary Registration District No. 2000

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:  
(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 Anna L. Stephens

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

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

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

7. Birth date of deceased Sept 18  
Month Day Year

8. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_ (less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) Ill

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 Oct Day 7 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 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 5 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) accident

(b) Date of occurrence Oct. 7 1945

(c) Where did injury occur On church steps, Springfield, Greene, Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Church of Christ entrance steps, Johnson and \_\_\_\_\_  
(Specify type of place)

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

23. Signature W. Verrell Jr (M. D. or other) \_\_\_\_\_  
Address Springfield Mo. Date signed 11/12/45

SUPPLEMENTARY

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

MOTHER, FATHER

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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