

S. No. 2
DM-2-43
v. 5-17-39
I X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36404

State File No. _____

FILED NOV 26 1945
149

Registrar's No. 4662

Registration District No. _____ Primary Registration District No. 1062

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Jackson City Mo.
(c) Name of hospital or institution: Northeast Hospital
(d) Length of stay: In hospital or institution 4 days
In this community 4 days

3. (a) PRINT FULL NAME: Nov. A. Stevenson
3. (b) If veteran, name war: NO
3. (c) Social Security: 459-26-4273

4. Sex: Male
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Angelia M. Stevenson
6. (c) Age of husband or wife if alive: 12 years
7. Birth date of deceased: 7 1886

8. AGE: Years 58, Months 11, Days 24

9. Birthplace: Missouri

10. Usual occupation: at home

MOTHER FATHER
11. Industry or business: _____
12. Name: John Stevenson
13. Birthplace: Missouri
14. Maiden name: Coleman
15. Birthplace: unknown

16. (a) Informant: Chas. A. Smith
(b) Address: Ind. Mo.

17. (a) Removal: _____ (b) Date thereof: 11/21/45

(c) Place: burial or cremation: Marceline Mo.

18. (a) Signature of funeral director: Stine McClure
(b) Address: Kansas City Mo.

19. (a) 11-11-45 (b) Signature of Registrar: Thaddeus Holmes

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: 58
(c) City or town: Marceline Mo.
(d) Street No.: _____
(e) Citizen of foreign country? _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11, day 11, year 1945, hour 6:55, minute P.M.

21. I hereby certify that I attended the deceased from 9-1-45 to 11-11-45
that I last saw him alive on 11-11-45 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic glomerulo-nephritis yr.

Due to: _____
Due to: _____

Other conditions: _____
Major findings: Of operations: 130

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): _____
(b) Date of occurrence: _____

(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature: Ralph Carhart (M.D. of Coroner)
Address: 1030 1/2 Ind. Ave. Ind. Mo. 46624

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

DEC - 5 1945

FEB 11 1946

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.....

Robert H. Reed

Licensed Embalmer No. *3745*

P. O. Address. *N. C. 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.