S. N.
1—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36695

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1212

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital () (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 Days (Specify whether

In this community 11 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess 31

(c) City or town Jamesport 0 (If outside city or town limits, write "RURAL")

(d) Street No. ----- 0 (If rural, give location)

(e) Citizen of foreign country? No / (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Lillie Belle Stevens

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 Married /

6. (b) Name of husband or wife Miner C. Stevens

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased June (Month) 30 (Day) 1891 (Year)

8. AGE:

Years	Months	Days	If less than one day
54	4	11	hr. min.

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

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name James D. Grubb
13. Birthplace Unknown (City, town, or county) Ohio (State or foreign country) /

MOTHER
14. Maiden name Mahulda Dockery
15. Birthplace Livingston County (City, town, or county) Missouri (State or foreign country) /

16. (a) Informant Miner C. Stevens

(b) Address Jamesport, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Jamesport, Missouri

18. (a) Signature of funeral director Hope Funeral Home

(b) Address Gallatin, Missouri

19. (a) Nov. 16-45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November Day 11 year 1945 hour 10 minute P M.

21. I hereby certify that I attended the deceased from Oct. 31-45, 19 , to Nov 11 1945 that I last saw her alive on Nov 11 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Left Hemiplegia Septic sore mouth (Multiple germs)	5 wks.
Due to Valvular heart disease past pneumonic left	5 yrs.
Due to Chest consolidation Left Hemiplegia probably embolic.	5 wks. 1 day
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 H. S. Conrad (M. D. ~~or other~~)

Address St Joseph Mo. Date signed 11-14-45

1428

(Licensed Embalmer's Statement on Reverse Side)

Concord
722 1/2 Francis St

DEC 10 1945

Hemiplegia

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. O. Richesson

Licensed Embalmer No. 3302

P. O. Address Gallatin, 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.

No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1212

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(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)

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

3. (a) PRINT FULL NAME Lillie B. Stevens

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased June 30 1899
(Month) (Day) (Year)

8. AGE: Years 54 Months 4 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 61
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death | Duration

Due to Bronchial pneumonia 3 wk.
with possible new
Due to growth (not admitted)

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.

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

107

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 H. S. Conrad (M. D. or other)

Address St Joseph Mo. Date signed 12-16-45

30095