

FILED AUG 8 1946

Registration District No. ~~111~~ 340 Primary Registration District No. 615-A

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Stoddard
 (b) City or town Charter Oak (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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard
 (c) City or town Charter Oak (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 EVERYLN DEANA STEPHENS

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased July 1 1944
 (Month) (Day) (Year)

8. AGE: Years 1 Months 11 Days 24 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name Herchel Stephens

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

14. Maiden name Lillian Drake

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

16. (a) Informant Bessie Turner, Grandmother
 (b) Address Canalou, Mo.

17. (a) Rural (b) Date thereof June 20, 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation N.M.O.

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

19. (a) July 19, 1946 (b) Lottie Jeffress
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24
 year 1946 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Struck by Press Locomotive Engine No. 1401. Duration _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 169.8 Of autopsy 19 **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) accident 113

Date of occurrence June 24, 1946

(c) Where did injury occur? Charter Oak Stoddard Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? near home

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C. A. Crane (M.D. or other) Crane
 Address Decker, Mo. Date signed _____

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

5-17-39 I X36671

RECEIVED

District Health Office No.

District File Number 846

Date Filed 8-5-9

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.....

Embalmer

Registered Apprentice No.....

working under my personal supervision.

Signed

John Allerton

Licensed Embalmer No.

2941

P. O. Address

Suburban

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.

State File No. Aug
Registrar's No. 11

Registration District No. 340

Primary Registration District No. 6151

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Charter Oak
(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 Evelyn D. Stephen

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1946 hour _____ minute _____ M.

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

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: July 1 (Month) 1913 (Day) 1913 (Year)

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

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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

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)

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M, D. or other) _____
Date signed _____

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.

259185