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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25987-A

Registration District No. 346

Primary Registration District No. 6166

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stone

(b) City or town Crane Route I
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
three south west of crane
(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) 73yr)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone

(c) City or town Crane R I.
(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 May Stephens

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife Deceased

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

7. Birth date of deceased May 27 1873
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>I</u>	<u>20</u>	hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Tom Moore

13. Birthplace unknown

14. Maiden name Effie Wilson
(State or foreign country)

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

16. (a) Informant Ralph Stephens

(b) Address Crane Route I.

17. (a) Burial (b) Date thereof July 9-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOS. HIGH CEMETERY

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-22-49 (b) MAS J. ELMER BROS. & SON
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7th
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 9 to July 7 1946
that I last saw her alive on July 7 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Larynx
Duration 18 Mo.

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy 47A

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

Signature A. P. Galt M.D. (M. D. or other)

Address Quincy, Mo. Date signed 6-23-49

H.C. (Licensed Embalmer) (Statement on Reverse Side)

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

JAN 24 1949

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.....

Licensed Embalmer No.....

P. O. Address.....

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.