

FILED MAR 31 1947

Registration District No. **17**

Primary Registration District No. **5551**
~~3025~~

Registrar's No. **50**

1. PLACE OF DEATH:

(a) County Hawell

(b) City or town Silviam Springs
(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 Mo (b) County Hawell

(c) City or town Silviam Springs
(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 Marion Lucille Stubbs

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 Child

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

7. Birth date of deceased 2 28 _____ (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 9
year 1947 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from 3 pm
9 Feb, 1947, to 6:30 pm Feb 9, 1947;
that I last saw her alive on Feb. 9, 1947,
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>8</u>	<u>11</u>	<u>17</u>	_____ hr. _____ min.

Immediate cause of death Circulatory collapse and pulmonary edema

Due to Progressive & rapid cardiac insufficiency

Due to _____

Other conditions renal insufficiency (probable)
(Include pregnancy within 3 months of death)

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

10. Usual occupation student

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER, FATHER

11. Industry or business _____

12. Name Ben Stubbs

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

14. Maiden name Bertie Collins

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

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? _____

16. (a) Informant Mrs. Ben Stubbs

(b) Address Silviam Springs

17. (a) B (b) Date thereof 2-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Silviam Springs

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Francis T. Francis (M. D. or other) D.O.

Address Willow Springs Mo Date signed 15-2-47

18. (a) Signature of funeral director Robertas

(b) Address West Plains, Mo

19. (a) 3-18-1947 (b) Beatrice Cook
(Date received local registrar) (Registrar's signature)

379

(Licensed Embalmer's Statement on Reverse Side)

Dr. Francis

JUN 1949
RECEIVED

District Health Officer No. 5,

District File Number 347168

Date Filed 3-28-47

APR 28 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.....

Robt. T. Drage....., Registered Apprentice No. 431
working under my personal supervision.

Signed S. A. Robertson.....

Licensed Embalmer No. 3435

P. O. Address West Plains,

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.

Registration District No. 141

Primary Registration District No. 5551

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Silsam Springs
(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 Marion I Stubbs

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 S

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

7. Birth date of deceased Feb 28 (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Howell
(c) City or town Silsam Springs (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 July year 1947 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.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 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) _____

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WHILE PLAINLY USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

B
15
3880

8858