

S. No. 2
M-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16104**

FILED MAY 14 1947

Registration District No. **334**

Primary Registration District No. **10-11-6**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Scott**

(b) City or town **near Blodgett Mo**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1 1/2 miles East
(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) **4 months**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **28**

(c) City or town **BOURBON - RURAL**
(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 **NONE**

3. (a) PRINT FULL NAME **GRACE LUCRETIA STEBBINS**

(b) If veteran, name war **No**

3. (c) Social Security No. **NONE**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **24th**
year **1947** hour **3** minute **22 P.M.**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced, **married**

(b) Name of husband or **HUSBAND** 6. (c) Age of husband or wife if alive **82** years

7. Birth date of deceased **Sept 30 1872**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **4/9**, 19**47**, to **4/24**, 19**47**
that I last saw her alive on **4/23**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** **3 da.**

8. AGE: Years **74** Months **6** Days **24** If less than one day hr. min.

Due to _____
Due to _____

9. Birthplace **NORTH HAMPTON MASS**
(City, town, or county) (State or foreign country)

Other conditions **Endocarditis** **9**
(Include pregnancy within 3 months of death)

10. Usual occupation **house wife - retired**
at home

Major findings:
Of operations _____
Of autopsy _____

11. Industry or business _____

MOTHER FATHER { 12. Name **GEORGE RUBEN REECE 4**

13. Birthplace **ENGLAND**
(City, town, or county) (State or foreign country)

14. Maiden name **ANNA WARTILDA WARNER**
(City, town, or county) (State or foreign country)

15. Birthplace **MASSACHUSETTS**
(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 Mary Shalhorn**

(b) Address **R. 2, Sikeston, Mo**

17. (a) **Burial + Removal** of Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation **Webster Grove Mo.**

(Specify type of place) _____ (e) Means of injury _____

23. Signature **J. A. Cline** (M. D. or other) _____
Address **Oran Mo** Date signed _____

18. (a) Signature of funeral director **Chas. H. Hunsell**

(b) Address **Oran Mo**

19. (a) _____ (b) **Mrs. E. Hunsell**
(Date received local registrar) (Registrar's signature) **2011**

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

MAR 20 1951

RECEIVED

District Health Office No. 2

District File Number 542-710

Date Filed 2-13-47

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2 710

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STATE OF MISSISSIPPI

MAY 9 1951

DEPARTMENT OF HEALTH
STATE OF MISSISSIPPI

22 AM

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

working under my personal supervision.

Registered Apprentice No.

Signed

John P. ...

Licensed Embalmer No. 3857

P. O. Address Charleston, W.V.

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.