

FILED APR 14 1948
Registration District No. 70

Primary Registration District No. 5302

Registrar's No. 6

2600

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

1. PLACE OF DEATH: *Cole Clark Troop*

(a) County *Cole*

(b) City or town *Brigato* (If outside city or town limits, write "RURAL" and name of township) *St. 2*

(c) Name of hospital or institution: *Five miles west of Brigato 1* (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *Five years* (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri*, (b) County *Cole* 26

(c) City or town *Brigato* "Rural" (If outside city or town limits, write "RURAL")

(d) Street No. *Five miles west of Brigato* (If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME *Ben Franklin Stogsdill*

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex *Male* 5. Color *White*

6. (a) Single, widowed, married, divorced *Married*

6. (b) Name of husband or wife *Fannie* 6. (c) Age of husband or wife if alive *70* years

7. Birth date of deceased *20 1874* (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<i>74</i>	<i>1</i>	<i>13</i>	hr. min.

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

10. Usual occupation *Farmer*

11. Industry or business *90 self*

12. Name *Denil Stogsdill*

13. Birthplace *Rolla Mo. 0* (City, town, or county) (State or foreign country)

14. Maiden name *Sarah Towser*

15. Birthplace *Rolla Mo. 0* (City, town, or county) (State or foreign country)

16. (a) Informant *Mrs Fannie Stogsdill*

(b) Address *Brigato Mo.*

17. (a) *Buried* (b) Date thereof *4-5-48* (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Parson*

18. (a) Signature of funeral director *Fernan Sewac*

(b) Address *719 Jefferson*

19. (a) *April 8 1948* (b) *Mrs T. R. Glover* (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* day *3* year *1948* hour *12* minute *30 P. M.*

21. I hereby certify that I attended the deceased from *Dead when received* to *1948* and that death occurred on the date and hour stated above

Immediate cause of death *Stagnulation of Hearting*

Due to *Suicide*

Due to _____

Other conditions (include pregnancy within 3 months of death) *16 40*

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *Suicide*

(b) Date of occurrence *April 3 - 48*

(c) Where did injury occur? *Cole Mo* (City or town) (County) (State)

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

While at work? *No* (Specify type of place)

(e) Means of injury *Rope*

23. Signature *J. Leslie Corbett* (M. D. or other) *3*

Address *Jefferson City* Date signed *4-5-48*

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed APR 13 1948

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
Walter R. Freeman, Registered Apprentice No. 481
working under my personal supervision.

Signed [Signature]
Licensed Embalmer No. 3641
P. O. Address [Signature]

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.