

FILED SEP 13 1948

Registration District No. **283**

Primary Registration District No. **3039**

Registrar's No. **188**

1. PLACE OF DEATH:

(a) County **Linn**
 (b) City or town **Marceline**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St Frances
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **8 Hrs.**
 (Specify whether
 In this community
 years, months or days)

3: (a) PRINT FULL NAME **Ida Virginia Stephenson**

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 **widowed**

(b) Name of husband or wife **James Winn Stephenson** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **December 10 1862**
 (Month) (Day) (Year)

8. AGE: Years **85** Months **8** Days **24** If less than one day hr. min.

9. Birthplace **Weston W. Virginia**
 (City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business

12. Name **Francis Kee**

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

14. Maiden name **Mariah Sampsel**

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

16. (a) Informant **Norman Stephenson**

(b) Address **Marceline Mo**

17. (a) **Burial** (b) Date thereof **Sept 7 1948**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt Olive**

18. (a) Signature of funeral director **James Mayhew**

(b) Address **Marceline Mo**

19. (a) **Sept 8 48** (b) **Mary Jane Owens**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Linn 58**
 (c) City or town **Marceline 2**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **W. Booker St 1**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, same country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **4**
 year **1948** hour **7** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Sept 7 1948** to **Sept 7 1948**
 that I last saw him alive on **Sept 7 1948**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Circulatory Collapse**
Cardiac Failure
Fracture Femur

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **1860**
 Of autopsy **1860**

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**

(b) Date of occurrence **Sept 5 48**

(c) Where did injury occur? **Marceline, Linn, Mo**
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
about home
 (Specify type of place) (e) Means of injury **Pt. Fall**

23. Signature **Robert W. Smith** (M. D. or **Dr. Jell**)

Address **Marceline, Mo** Date signed **Sept 7 1948**

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

MOTHER FATHER

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 *Blanche M. Langley*
Licensed Embalmer No. *1909*
P. O. Address *Marcelline*

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.