

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. _____

Primary Registration District No. **5236**

1. PLACE OF DEATH:

(a) County Cedar
(b) City or town Rural Box
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: X
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X (Specify whether
In this community X years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. X (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME William B. Stamps

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Minnie L. Stamps 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased December 9, 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>8</u>	<u>20</u>	hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business Farming

12. Name Calvin Stamps
13. Birthplace Kentucky (City, town, or county) (State or foreign country)
14. Maiden name Alice Bray
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Minnie L. Stamps
(b) Address Stockton, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-48
(Month) (Day) (Year)

(c) Place: burial or cremation Mound
18. (a) Signature of funeral director Charles H. Speake
(b) Address Stockton, Missouri

19. (a) 3 48 (Day received local registrar) (b) Jo. B. ... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month aug day 29
year 1948 hour 9:2 minute 15 P. M.

21. I hereby certify that I attended the deceased from 8-6- 1948 to 8-24- 1948
that I last saw him alive on 8-24-48 and that death occurred on the date and hour stated above.

Immediate cause of death Undetermined
Due to Severe secondary anemia months
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 738
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? U

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Wm. B. Richter (M. D. or other)
Address Stockton, Mo. Date signed 8-31-48

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

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

DEC 16 1948

RECEIVED

District Health Officer No. 7,

District File Number 8-48-1088

Date Filed 9-18-48

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 Melvin Church

Licensed Embalmer No. 3272

P. O. Address Stockton Mo

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.