

FILED SEP 20 1948

Registration District No. 360

Primary Registration District No. 3076

Registrar's No. 147

1. PLACE OF DEATH:

(a) County VERNON  
(b) City or town NEVADA  
(c) Name of hospital or institution: NEVADA CITY HOSP.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 DAYS  
In this community 26 YEARS  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County BATES  
(c) City or town P.O. Hill - OSAGE TWP.  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6TH & OAK ST.  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 6  
year 1948 hour 12 minute 25 AM.  
21. I hereby certify that I attended the deceased from August 27 1948 to SEPT 6 1948  
that I last saw him alive on SEPT 6 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death: Apoplexy, Cerebral Scurvy Duration 2 days

Due to HYPERTENSION ?

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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) \_\_\_\_\_  
(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? \_\_\_\_\_  
(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Wm. J. Miller, M.D. (M.D. or other)  
Address Nevada Mo Date signed 9-12-48

3. (a) PRINT FULL NAME SARAH ANN STODDARD

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 MARRIED

6. (b) Name of husband or wife ALBERT W. STODDARD 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased JANUARY - 11 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
60 7 25 - hr. - min.

9. Birthplace CLARKSVILLE ARKANSAS  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business \_\_\_\_\_

12. Name JOHN CLYMER

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name SUSAN MORRIS

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant Albert W. Stoddard

(b) Address P.O. Hill, Mo.

17. (a) BURIAL (b) Date thereof SEP-8-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CARBON CENTER CEM.

18. (a) Signature of funeral director Booth

(b) Address P.O. Hill, Mo.

19. (a) 9-14-48 (b) Walter Vasey  
(Date received local registrar) (Registrar's signature)

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

8

2

RECEIVED

District Health Officer No. 74

District File Number 8-48-1090

Date Filed 9-18-48

JAN 31 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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed John G. Underwood  
Licensed Embalmer No. 3585  
P. O. Address Butler 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.