

Registration District No. 121 Primary Registration District No. 5747 Registrar's No.

1. PLACE OF DEATH:

(a) County BARRY
(b) City or town RURAL JENKINS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
in this community LIFE TIME years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Susie Luella Stockton

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife E.C. Stockton 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Jan 13 1884
(Month) (Day) (Year)

8. AGE: Years 64 Months 9 Days 18 If less than one day 0 hr. min.

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

10. Usual occupation House Wife

11. Industry or business _____

12. Name James Doty D

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

14. Maiden name Sarah Johnson

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

16. (a) Informant E.C. Stockton

(b) Address Jenkins Mo

17. (a) Burial (b) Date thereof 11 9 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation King Cemetery

18. (a) Signature of funeral director Cassville

(b) Address Cassville Missouri

19. (a) Nov 4/9/51 (b) Mrs Gene Anderson
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31
year 1948 hour 8 minute AM

21. I hereby certify that I attended the deceased from Oct. 2 1948 to Oct. 30 1948
that I last saw him alive on Oct. 30 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration _____

Due to _____

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?
While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Herbert H. Salzer M.D. (M. D. or other)

Address Cassville Mo Date signed _____

WHILE PRINTING—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER: FATHER

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

Paul D. Kenbest

Licensed Embalmer No. *4576*

P. O. Address *Cassville*

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.

STANDARD CERTIFICATE OF DEATH

State File No. 42 983
 Registrar's No. 49

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. 4026 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Barry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN <u>Rural--Jenkins</u> <small>(If outside corporate limits, write RURAL and give township)</small>		c. CITY OR TOWN _____ <small>(If outside corporate limits, write RURAL and give township)</small>	
c. LENGTH OF STAY (in this place) <u>Life</u>		d. STREET ADDRESS _____ <small>(If rural, give location)</small>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>SUSIE</u>	b. (Middle) <u>LUELLA</u>	c. (Last) <u>STOCKTON</u>	(Month) <u>October</u>	(Day) <u>31</u>	(Year) <u>1978</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years, last birthday)	10. CITIZEN OF WHAT COUNTRY?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
_____	_____	_____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(Yes, no, or unknown) (If yes, give war or dates of service)</small>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*		
	ANTECEDENT CAUSES		
	Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (a) _____		
	DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Glenn W. Salver, M. D.</u> <small>(Degree or title)</small>	23b. ADDRESS <u>Cassville, Missouri</u>	23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11/2/48</u>	24c. NAME OF CEMETERY OR CREMATORY <u>King Cemetery</u>
DATE REC'D BY LOCAL REG. <u>4-9-51</u>	REGISTRAR'S SIGNATURE <u>Mrs. Gene Hudson</u>	24d. LOCATION (City, town, or county) (State) <u>Cassville Mo.</u>
25. FUNERAL DIRECTOR'S SIGNATURE <u>Culver's</u>		ADDRESS <u>Cassville, Missouri</u>

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

SUPPLEMENTAL

