

REC'D DEC 19 1938

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

 29689
 Do not use this space.

1. PLACE OF DEATH

 (a) County Linn
 (b) Township Baker
 (c) City

 Registration District No. 506
 Primary Registration District No. 5671

Registered No. _____

 (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

 (a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

LOUISE JANE STUFFLEBEAN

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

 5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF BELAM STUFFLEBEAN
 (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

 7. AGE YEARS 79 MONTHS 9 DAYS 1 If LESS than 1 day, _____ hrs. or _____ min.

 OCCUPATION 8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. House wife
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chicago IllFATHER 13. NAME Clark14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UnknownMOTHER 15. MAIDEN NAME Unknown16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown17. INFORMANT (ADDRESS) Sam Stufflebean18. BURIAL, CREMATION OR REMOVAL PLACES Stufflebean cemetery DATE Nov 3, 193819. FUNERAL DIRECTOR (ADDRESS) Anderson Funeral Service20. FILED Nov 8, 1938 Gertrude Williams Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 21, 193822. I HEREBY CERTIFY, That I attended deceased from 10/24, 1938, to 11/3, 1938
 I last saw her alive on 11/3, 1938. Death is said to have occurred on the date stated above, at 10:30 AM.

 The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia

Date of onset

Other contributory causes of importance: 108

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No, specify _____
 (Signed) A. C. Knapp M. D.
Bucklin, 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.....

Licensed Embalmer No.

P. O. Address.....

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, above space should be left blank.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39689
Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 506
(b) Township Baker Primary Registration District No. 3671
(c) City _____ (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 2, 1859

7. AGE YEARS 79 MONTHS 9 DAYS 1 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19__

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Nov 3 1938 Bertine Williams
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 2 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19__

I last saw him _____ alive on _____, 19__. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19__

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) D. C. Isgreen _____, M. D.

(Address) Birken _____

