LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 42212

1 PLACE OF DEATH

County Pinscot 6

Township 6

or

Village

or

City Caruthersville (NO. ..... St.; ..... Ward)

Registration District No. 651 File No. .....

Primary Registration District No. 4388 Registered No. 255

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME D. C. Stevens

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Feb. (Month) 15th (Day) 1888 (Year)

7 AGE: 29 yrs. 9 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Common Laborer
(b) General nature of industry business, or establishment in which employed (or employer): do

9 BIRTHPLACE (City or town, State or foreign country): Lauterdale Co. Tenn.

PARENTS

10 NAME OF FATHER: Cal. Stevens

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Middle Tenn.

12 MAIDEN NAME OF MOTHER: C. P. Winbury

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Henderson Co. Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. R. Stevens

(Address) Caruthersville Mo.

15

Filed 12-13, 1917. B. D. Crowe, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 12th (Day), 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 12th, 1917, to Dec 12th, 1917, that I last saw him alive on Dec 12th, 1917, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

23A 48 (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. B. Hendrix M. D.

Dec 13th, 1917 (Address) Caruthersville Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. 3 mos. ..... ds. In the State 8 yrs. 3 mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence: Arkansas

19 PLACE OF BURIAL OR REMOVAL: Caruthersville Mo. DATE OF BURIAL: Dec 14, 1917

20 UNDERTAKER: J. R. Lewis ADDRESS: Caruthersville Mo.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIST
CERTIFICATE OF DEATH

Revised United States Standard Certificate of Death

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7 AGE ..... yrs. ..... mos. ..... ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) (Da

17 I HEREBY CERTIFY, that I attended .....

..... 191....., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. .....

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. .....

(Signed) .....

..... 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Vi
(1) Means of Injury; and (2) whether Accidental, Suici

18 LENGTH OF RESIDENCE (For Hospitals, Institut
or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. — In the State ..... yrs.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL — DATE O

20 UNDERTAKER — ADDRES

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.; Carcinoma, Sarcoma, etc.,* of ..... (name ori-

"Cancer" is less definite. Avoid use of "Tumor"

Issued by the Bureau of Census and American Public Health A

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