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

30453

1 PLACE OF DEATH

County: St Louis

Township: Central

or

Village:

or

City: (NO. Overland Park Mo St.; Ward)

Registration District No. 790 File No.

Primary Registration District No. 6033 Registered No. 72

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

2 FULL NAME John C Stillman

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: Oct 24 1838 (Month) (Day) (Year)

7 AGE: 79 yrs. 10 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.?

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

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

PARENTS

10 NAME OF FATHER: James Stillman

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

12 MAIDEN NAME OF MOTHER: Mercy Bailey

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Robert P Stillman
(Address): Overland Park

15 Filed 9/19 1918 J B Sudduth Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 17th (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept. 3 1918 to Sept. 17 1918 that I last saw h. alive on Sept. 17th 1918 and that death occurred, on the date stated above, at 5:20 p.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis - Tolerance

97

1 yr

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Chronic Indigestion

(Duration) yrs. 2 mos. ds.

(Signed) H. T. Coleman M. D.

Sept. 18 1918 (Address) Pattonville 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. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Peters Cem DATE OF BURIAL: Sept 19 1918

20 UNDERTAKER: Mullen & Co ADDRESS: 4069 St Louis

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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)

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

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
..... (Month) ....., (Day) 1..... (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
....., 191.....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from
....., 191....., to....., 191.....
that I last saw h.....alive on....., 191.....,
and that death occurred, on the date stated above, at.....m.
The CAUSE OF DEATH* was as follows:

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

CONTRIBUTORY .....
(Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.
....., 191..... (Address).....

*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.....mos.....ds. In the State.....yrs.....mos.....ds.

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

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL
..... 191.....

20 UNDERTAKER | ADDRESS

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

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