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

Do not use this space.

1354

File No. .....

Registered No. 10

1. PLACE OF DEATH
County Howell
Township Willow Spgs
City Willow Springs Mo. (No. ....., ... St. ..... Ward)

Registration District No. 395
Primary Registration District No. 5536

2. FULL NAME Mr Ira Stephenson.

(a) Residence. No. Willow Springs. Mo. St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mrs Ira Stephenson

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec. 6. 1861

7. AGE: Years 68 | Months 1 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: James Stephenson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Holt County. Missouri

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know

14. INFORMANT: I. G. Stephenson. I. G. Stephenson
(Address) Willow Springs. R.F.D./

15. FILED 1/19, 1929 J. B. Ferguson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1-17-1929

17. I HEREBY CERTIFY, That I attended deceased from 11-17- 1928 to 1-17- 1929 that I last saw him alive on Jan 12-20, 1928 and that death occurred, on the date stated above, at 6 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
apoplexy
82A Died instantly
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) None
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? At place of death

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Prolonged case & family Hx.

(Signed) J. E. Burns M. D.
1-17, 1929 (Address) Willow Springs Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. None

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: ~~City Cemetery~~ Pine Grove

DATE OF BURIAL: 1/20/.29

20. UNDERTAKER: R Burns

ADDRESS: Willow Springs Mo

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Howell — Registration District No. 285 — File No. .....

Township Willow Spgs — Primary Registration District No. 5536 — Registered No. 10

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Ira Stephenson

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 6 - 1860

7. AGE: X — YEARS: 68 — MONTHS: 1 — DAYS: 11 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

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

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 3/15 1929 J B Ferguson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 17 1929 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19....., that I last saw h..... alive on ....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

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.

...S SHALL NOT RECEIVE A FEE FOR CERTIFI... THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-1354