

REC'D MAR 9 1939

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

5265

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Law Primary Registration District No. \_\_\_\_\_ Registered No. 461  
(c) City K. C. Mo. (d) Street No. General Hospital #2 St. \_\_\_\_\_  
(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

314 Joe Stubblefield  
(a) Residence, No. 2908 Forest (Base) 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 male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-25-1885  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 53 1 1

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

FATHER 13. NAME Unknown  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (NAME) Record Clerk  
(ADDRESS) General Hospital #2

18. BURIAL, CREMATION, OR REMOVAL interred DATE 2nd 6th 39

19. FUNERAL DIRECTOR (NAME) West Jefferson  
(ADDRESS) 1905 Vine

20. FILED 214 1939 M. Browne  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-26 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-16 1939 to 1-26 1939  
I last saw him alive on 1-26 1939 Death is said to have occurred on the date stated above, at 7:50 A. M.  
The principal cause of death and related causes of importance were as follows:

Fecal Fistula & Peritonitis following operation for Gangrenous Appendix in a Strangulated Inguinal Hernia  
Date of onset \_\_\_\_\_

Other contributory causes of importance: 122a

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? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) J. A. Brown M. D.  
(Address) General Hospital #2

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. *2710*

P. O. Address *1205 Vine*

**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.**