

W & A

OCT 19 1939

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

32998
Do not use this space.

1. PLACE OF DEATH

(a) County Miller Registration District No. 561

(b) Township Springe Rural Primary Registration District No. 5-756A Registered No. 518

(c) City Clear (d) Street No. _____

(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 Nancy Caroline Stubblefield

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Philip M. Stubblefield

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 22 1853

7. AGE YEARS 86 MONTHS 6 DAYS 20 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. Housewife

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) Missouri

13. NAME William Long

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

15. MAIDEN NAME Polly Clark

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

17. INFORMANT Mrs. Gen. Templeton (ADDRESS) Clear, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Allen (C.) DATE Sept. 13 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Phillips Funeral Home Clear, Mo.

20. FILED 9-13 1939 Belle Haynes Leat Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 12 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 11 1939 to Sept 12 1939

I last saw him alive on Sept 11 1939. Death is said to have occurred on the date stated above, at 6:45 P.M.

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

Gas shock from face & respiratory system

Other contributory causes of importance: General Debility

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) W. J. Allen

(Address) Clear, Mo.

MARGIN RESERVED FOR BINDING

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.

V. S. NO. 2.
5014-1-12-39
I X14223

RECEIVED

Miller County Health Dep't.

County File Number 39-112

Date Filed 10-10-39

136 ad

NOT EMBALMED

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

32998

Do not use this space.

1. PLACE OF DEATH

(a) County Miller Registration District No. 561
 (b) Township Saline Primary Registration District No. 5755-A Registered No. _____
 (c) City _____ (d) Street No. _____ 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 Nancy Caroline Stubblefield

(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) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
86 6 20

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 _____ 19____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-12-39

22. I HEREBY CERTIFY, That I attended deceased from 9-11-39 to 9-12-39

I last saw her alive on 9/11, 1939. 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:

skate from fall resulting in injury to head - 9-11-39. After having attempted to get from bed she fell and was unable to rise. Other contributory causes of importance: General senility.

Date of onset 9-11-39

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? accident Date of injury 9-11-39

Where did injury occur? the home near 6000 Ave.

(Specify city or town, county, and State)

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

Manner of injury fall from bed

Nature of injury fracture of hip near femur

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

If so, specify _____

(Signed) W. L. Adkins, M. D.

(Address) Eldon

SUPPLEMENT

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.

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



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