

FILED APR 23 1940

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

11657

Do not use this space.

1. PLACE OF DEATH

(a) County Maries Registration District No. 543
 (b) Township Boone Primary Registration District No. 5743 Registered No. 3
 (c) City Near Meta (d) Street No. 7/0 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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 Washington Lafayette Stokes

(a) Residence, No. 717 St. 7 (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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11/22/1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
94 3 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 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) Tennessee13. NAME Edward Lafayette Stokes14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee15. MAIDEN NAME Nancy Jane Eve16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee17. INFORMANT (ADDRESS) Frank Stokes
Meta, Missouri18. BURIAL, CREMATION, OR REMOVAL PLACE Stokes Cemetery DATE 3/2, 194019. FUNERAL DIRECTOR (NAME) (ADDRESS) Fred H. Gilbert
Dixon, Missouri20. FILED March 21, 1940 Mrs. Rosa Lawson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/1, 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 27, 1940, to Feb 29, 1940
 I last saw him alive on Feb 29, 1940. Death is said to have occurred on the date stated above, at 11 A.M.
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage 2/26/40
Impacted fracture of neck of femur 2/26/40

Other contributory causes of importance:

Name of operation None Date of 2/26/40
 What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? None Date of injury 2/26, 1940
 Where did injury occur? In home, Maries Co
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

home Cerebral Hemorrhage
 Manner of injury Fall to floor due to carb-
 Nature of injury Fracture of neck of femur

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify None
 (Signed) Donald H. Hales, M.D.
 (Address) Brinktown, Mo

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11637

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 343

Primary Registration District No. 5743

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County. Marion

(b) City or town. Bonne
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (If outside city or town limits write "RURAL")

(d) Street No..... (If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME Washington R. Stokes

19. MEDICAL CERTIFICATION

3. (b) If veteran, name war..... 3. (c) Social Security No.....

20. DATE OF DEATH Month 3 day 1
year 1940 hour..... minute..... M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced.....

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....
that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

Immediate cause of death.....

7. Birth date of deceased..... (Month)..... (Day)..... (Year).....

8. AGE: Years 94 Months 3 Days 3 If less than one day..... hr..... min.

Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

9. Birthplace..... (City, town, or county)..... (State or foreign country).....

10. Usual occupation.....

Major findings:
Of operations.....
Of autopsy.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county)..... (State or foreign country).....

14. Maiden name.....

15. Birthplace..... (City, town, or county)..... (State or foreign country).....

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) March 21 1940 Mrs Rosa Larson (b) Registrar's signature

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town)..... (County)..... (State).....
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place)..... (e) Means of injury.....
23. Signature Dorley Gately (M. D. or other).....
Address Brunswick Date signed.....

Duration.....
PHYSICIAN.....
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

11657 (1940)