

No. 1-10-39
-17-39
X218

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14298

Registration District No. **85**

Primary Registration District No. **1001**

State File No. _____
Registrar's No. **384**

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2524 S. 4th. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 50 years
years, months or days 330

8. (a) PRINT FULL NAME WILLIAM STOUT
8. (b) If veteran, name war no
3. (c) Social Security No. None

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

6. (b) Name of husband or wife Nellie Stout
6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased February 15, 1874
(Month) (Day) (Year)

8. AGE: Years 66 Months 1 Days 16
If less than one day hr. _____ min. _____

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

10. Usual occupation Packer

11. Industry or business Larabee Mills

MOTHER FATHER { 12. Name Samuel Stout
13. Birthplace Buchanan County Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Thomas
15. Birthplace Buchanan County Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nellie Stout

(b) Address 2524 S. 4th. St. Joseph

17. (a) burial (b) Date thereof 4-5-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address St. Joseph, Mo.

19. (a) Apr 5, 1940 W. J. Nestlebusch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits write "RURAL")
(d) Street No. 2524 S. 4th.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1st.
year 1940 hour 9 minutes 30 p. M.

21. I hereby certify that I attended the deceased from APRIL 1, 1940 to _____, 19____;

that I last saw the decedent _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy

Due to _____

Due to _____

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy none

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? _____

85 While at work? _____ (Specify type of place) _____

(e) Means of injury _____

23. Signature B. W. Tackley Coroner (M. D. or other) _____

Address King Hill Bldg Date signed 4/5 1940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

C. G. Swan

Licensed Embalmer No. 4082

P. O. Address St Joseph

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.