

15-17-39
I X23159

Registration District No. **260**

Primary Registration District No. **5368**

Registrar's No.

1. PLACE OF DEATH:

(a) County **DE KALB Grand River**

(b) City or town **U.S. HIGHWAY #36**
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community **3 yrs.** years, months or days **2 1/2**

3. (a) PRINT FULL NAME **GLEN STEVERSON**

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **500-07-5248**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **LENA** 6. (c) Age of husband or wife if

7. Birth date of deceased **Oct 7 1914**
(Month) (Day) (Year)

8. AGE: Years **26** Months **9** Days **4** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business **SUPT. W.P.A. PROJECT**

12. Name **unknown W.D. Stevenson**

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

14. Maiden name **Ethel Eckles**

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

16. (a) Informant **Mr. E. Danul**

(b) Address **Weatherly MO**

17. (a) **Graham Mo** (b) Date thereof **7-14-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Graham Mo**

18. (a) Signature of funeral director **J.W. PALAND**

(b) Address **Carvers Mo**

19. (a) **7-13-40** (Date received local registrar) (b) **Melred Mc Mahall** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **DE KALB**

(a) State **Weatherly** (b) County **Clanton**

(c) City or town **Carvers Weatherly**
(If outside city or town limits, write "RURAL")

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **17th** year **1940** hour **12** P.M. minute _____ M.

21. I hereby certify that I attended the deceased from **July 17** 19**40** to **July 17** 19**40** that I last saw him alive on **July 10** 19**40** and that death occurred on the date and hour stated above.

Immediate cause of death **accidental (automobile)**

Due to **mangled body**

Due to _____

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

Major findings: _____ Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **accident**

(b) Date of occurrence **12:30 P.M. July 17-1940**

(c) Where did injury occur? **U.S. Highway 36** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **no**

While at work? **no** (Specify type of place) Means of injury **5**

23. Signature **Dr. M. S. Gale** (M. D. or other) **Carvers**

Address **Osborn Mo** Date signed **7/14/40**

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

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

RECEIVED

District Health Officer ~~_____~~ #1,

District File Number 840-1292

Date Filed 14 1940

210
98

AUG 23 1938

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 Geo E Daynie
James Scott Hucks
Licensed Embalmer No. 4092 3300

P. O. Address Wheatley, Mo

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25053

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 260

Primary Registration District No. 5363

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County DeKalb
(b) City or town Grand River Twp.
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Glen Stiversson

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

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

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

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

8. AGE: Years 26 Months 9 Days 4 If less than one day hr. min.

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

10. Usual occupation _____

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)

(Burial, cremation, or removal) _____ (c) Place: burial or cremation _____

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

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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

19. DATE OF CERTIFICATION

20. DATE OF DEATH Month July day 12 year _____ hour _____ minute _____ M.

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

Immediate cause of death accidental Automobile Duration _____
strangled body

Due to Automobile leaving road in a curve of 61° 37' cut bank

Due to ing on opposite side curb causing death of

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

Major findings: Of operations _____

Of autopsy 210 9 10

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence July 12 - 1940

(c) Where did injury occur? Osborn Penick mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? U.S. Highway

While at work? no (Specify type of place) (e) Means of injury _____

23. Signature W.S. Gale (M. D. or other) _____
Address Osborn Date signed _____

Coroner DeKalb County mo.

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25-053-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 260

Primary Registration District No. 3363

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Desha
(b) City or town Grand River
(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)

3. (a) PRINT FULL NAME Glen Stevenson

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

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

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

7. Birth date of deceased Oct 7 1914
(Month) (Day) (Year)

8. AGE: Years 25 Months 9 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-13-40 (b) Mildred Mc Mahall
(Date received local registrar) (Registrar's signature)

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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
year 1940 hour _____ minute _____ M.

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.
Immediate cause of death _____

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

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 H. S. Gule (M. D. or other) _____
Address Osborn Date signed _____

SUPPLEMENTAL COPY