DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

25122

State File No. ✓

Registration District No. 293 Primary Registration District No. 5411 Registrar's No.

1. PLACE OF DEATH:
(a) County: Franklin Co.
(b) City or town: Gray Summit, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Gray Summit, Mo. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ✓ (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County:
(c) City or town: Gray Summit (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: William J. Stevenson
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Alma
6. (c) Age of husband or wife if alive: 67 years
7. Birth date of deceased: October 18, 1867 (Month) (Day) (Year)
8. AGE: Years 72 Months 9 Days 13 If less than one day hr. min.
9. Birthplace: Canada ✓ (City, town, or county) (State or foreign country)
10. Usual occupation: Nil
11. Industry or business:
FATHER 12. Name: Unknown Stevenson
13. Birthplace: Unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature: Alma B. Stevenson
(b) Address: Gray Summit, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/3/40 (Month) (Day) (Year)
(c) Place: burial or cremation: Valhalla
18. (a) Signature of funeral director: Edith E. Ambruster
(b) Address: 4234 Manchester
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1940 hour minute 3.12 A.M.
21. I hereby certify that I attended the deceased from July 29th, 1940, to July 31st, 1940, that I last saw him alive on July 30, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	9 days.
Due to ✓	
DIN	
Due to ✓	
Other conditions (Include pregnancy within 3 months of death): Paralysis Agitans	10 years.

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? (Specify type of place)
While at work? ✓ (e) Means of injury ✓

23. Signature: Otto E. Barthup (M. D. or other)
Address: Pacific, Mo. Date signed 8-1-40

(Licensed Embalmer's Statement on Reverse Side)

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.

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 Thomas Eynck

Licensed Embalmer No. 1284

P. O. Address St Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

o. 2B
-21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25-122

Registration District No. 293 Primary Registration District No. 3411 Registrar's No.

1. PLACE OF DEATH:
(a) County Franklin
(b) ~~City or town~~ Boles T. P.
(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 years, months or days)
In this community

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 Wm J 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 (Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 13 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)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 8-1-40 (Date received local registrar) (b) Mary B Gross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 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 , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature H. E. Barthen (M. D. or other)
Address Pacific Mo. Date signed

SUPPLEMENTARY