

Registration District No. **8-16**

Primary Registration District No. **6065**

Registrar's No. **37**

1. PLACE OF DEATH:
 (a) County **Scott**
 (b) City or town **Royal Sylvania 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 **2**
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Joseph Coleman Story**
 3. (b) If veteran, name war.
 3. (c) Social Security No. **702-12-8334**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Millie May Story**
 6. (c) Age of husband or wife if alive **48** years
 7. Birth date of deceased **Oct 8 1888**
 (Month) (Day) (Year)

8. AGE: Years **52** Months **0** Days **10** If less than one day hr. min.

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

10. Usual occupation **RR. Engineer**

11. Industry or business

MOTHER FATHER
 { 12. Name **Ben B Story**
 { 13. Birthplace **Benton, Mo**
 (City, town, or county) (State or foreign country)
 { 14. Maiden name **Dora Griffith**
 { 15. Birthplace **Dont Know**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Joe Story, Jr**
 (b) Address **Chaffee Mo**

17. (a) **Burial** (b) Date thereof **10-20-40**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cape Co.**

18. (a) Signature of funeral director **Riflinghoff - Hubbard**

(b) Address **Chaffee, Mo**

19. (a) **10/20/40** (b) **W. J. ...**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Scott**
 (c) City or town **Royal Sylvania Township**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **0**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION **18 18th**
 20. DATE OF DEATH: Month **Oct** day **18th**
 year **1940** hour minute M.
 21. I hereby certify that I attended the deceased from **attended as coroner**
 to **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 **Acute Myocarditis**
 Due to **Fatal about 1 hour after death had occurred near where deceased had been cutting weeds**
 Due to **after death had occurred near where deceased had been cutting weeds**
 Other cause of death **cutting weeds**
 (Include pregnancy within 3 months of death)
 Major findings: **About 11 a.m. Sudden death (heart attack)**
 Of operations
 (Of autopsy)
 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? **Scott County**
 (Specify type of place) (e) Means of transport **Coroner**

23. Signature **J. Charleson** (M.D. or other)
 Address **Charleston Mo** Date signed **10-19-40**

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

Nov. 5-17-39 I X19311

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.

RECEIVED

District Health Officer No. 2,

District File Number 1140-16

Date Filed 11/2/40

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 Mamie Desplanghoff

Licensed Embalmer No. 3242

P. O. Address Chester 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36526
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 820

Primary Registration District No. 6069

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

1. PLACE OF DEATH:

(a) County Leitch
(b) City or town Sylvania, Mo.
(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 _____
In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town Chaffee Rural
(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

Joseph Coleman Story

(b) If veteran, name war _____

(c) Social Security No. _____

MEDICAL CERTIFICATION

4. DATE OF DEATH: Month 10 day 18
year _____ 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.

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 _____ year

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

8. AGE: Years 22 Months - Days 10 If less than one day _____ hr. _____ min.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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

MOTHER FATHER { 12. Name _____

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

14. Maiden name (City, town, or county) (State or foreign country)

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)

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

19. (a) 1/9/41 (b) W. J. ... (Date received local registrar) (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 Geo M. ... (M. D. or D.O.)
Address Charleston Mo Date signed _____

also 10-29-40

