DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 10 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41824

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 1263

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

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: Mens Bureau, 108 No. 2nd St. (If not in hospital or institution, write street number or location) 3
(d) Length of stay: In hospital or institution: 9 months (Specify whether
In this community: Lifetime years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: Rural (If outside city or town limits, write "RURAL")
(d) Street No.: R.F.D.# 4 (If rural, give location)
(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: Harvey Stephens

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: Single
6. (b) Name of husband or wife: None
6. (c) Age of husband or wife if alive: None years
7. Birth date of deceased: ? (Month) ? (Day) 1865 (Year)

8. AGE: Years 75 | Months ? | Days ? | If less than one day ..... hr. ..... min.

9. Birthplace: Buchanan County, Missouri (City, town, or county) (State or foreign country) 0
10. Usual occupation: Retired Farmer 9
11. Industry or business: None 1
FATHER
12. Name: Unknown 9
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: Records Social Welfare Board
(b) Address: 10th & Patee, St. Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 3, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Joseph City Cemetery
18. (a) Signature of funeral director: John E. Rupp
(b) Address: 6054 Pryor Ave.
19. (a) Dec 2-40 (Date received local registrar) (b) H. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 1 day 1 year 1940 hour 12 minute 15 A. M.
21. I hereby certify that I attended the deceased from March 21, 1940 to Nov 30, 1940 that I last saw him alive on Nov 30, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cancer of Stomach & Transverse Colon	10 M
Due to	
Due to	
Other conditions: Starvation (Include pregnancy within 3 months of death)	1 M

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): No
(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)
85 While at work? ✓ (e) Means of injury ✓
23. Signature: Charles H. Werner (M.D. or other) 1
Address: 221 Kirkpatrick Bldg. Date signed: 12-2-40

(Licensed Embalmer's Statement on Reverse Side) ST. JOSEPH

#6

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 Myself, Registered Apprentice No. ..... working under my personal supervision.

Signed John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St. Joseph, Missoouri

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, fact should be so stated above.

No. 2B
-2-21-40
I 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. 41824

Registration District No. 85 Primary Registration District No. 1021 Registrar's No. 1263

1. PLACE OF DEATH:

(a) County Bu[illegible] Grange

(b) City or town [illegible] (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 Harvey Stephens

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 S

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 75 Months ? Days ? 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) (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) Feb. 10-1941 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1 year 1940 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 Cancer of Stomach and Transverse Colon — Duration

Due to Primary Seat Transverse Colon

Due to

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

Major findings:
Of operations 1-6

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 [illegible] (M. D. ~~or other~~) M.D.

Address [illegible] Date signed 2-10-41

SUPPLEMENTARY

221 Independence