

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.

1. PLACE OF DEATH:

(a) County Cedar

(b) City or town Liberty

(c) Name of hospital or institution: I.O.O.F. Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 yrs. 7 months. 17 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William G. Stockwell

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color of race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife not known

6. (c) Age of husband or wife if alive dead years

7. Birth date of deceased March 6, 1856  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>8</u>	<u>12</u>	hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Leiston Stockwell

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

14. Maiden name Sardine

15. Birthplace Unknown N.Y.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Paul Rogers

(b) Address Liberty, Mo.

17. (a) Burial (b) Date thereof 11-20-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation I.O.O.F. Home

18. (a) Signature of funeral director Joseph Gardner

(b) Address Liberty, Mo.

19. (a) 11-20-40 (b) Aileen Early  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cedar

(c) City or town Rural Liberty West.  
(If outside city or town limits, write "RURAL")

(d) Street No. P.F.O. # 3 Liberty Mo.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 18  
year 1940 hour 5:45 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Oct 1, 1938 to Nov 11, 1940  
that I last saw him alive on Nov 11, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Thrombo-embolism of the arteries

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to again

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: \_\_\_\_\_

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? 940  
(Specify type of place)

While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature A.H. Matthews (M. Doctor)

Address Liberty Mo Date signed 11/1/40

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 1-6-41

**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 *Marie Hessel*

Licensed Embalmer No. *2509*

P. O. Address *Liberty 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.**