S. No. 21 1 2 v. 5 1 4

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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. 43493

Registration District No. JAN 25 1941 677 Primary Registration District No. 4403 Registrar's No. 152

**1. PLACE OF DEATH:**
(a) County Phelps
(b) City or town Rolla
(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 3

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Missouri (b) County Tex, Co
(c) City or town
(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.

3. (a) PRINT FULL NAME Thomas .J.Givens
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race Wht
6. (a) Single, widowed, married, divorced ✓
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Don't Know (Month) (Day) 1863 (Year)
8. AGE: Years 87 Months — Days — If less than one day hr. min.
9. Birthplace Texas Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business
FATHER 12. Name Samuel Givens
13. Birthplace Virginia (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Susan Boggs
15. Birthplace Virginia (City, town, or county) (State or foreign country)
16. (a) Informant Geo Keeney
(b) Address Rolla, Mo
17. (a) Arthurs Creek (Burial, cremation, or removal) (b) Date thereof 12/ 24/40 (Month) (Day) (Year)
(c) Place: burial or cremation Arthurs Creek Tex Co
18. (a) Signature of funeral director [illegible]
(b) Address [illegible]
19. (a) Dec. 26, 1940 (Date received local registrar) (b) Jos. F. Ayers (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 23 year 1940 hour 2 minute 0 P M.
21. I hereby certify that I attended the deceased from Dec 1 1940, to Dec 22 1940 that I last saw him alive on Dec 20 1940; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Ch. Myocarditis | |
| Due to Ch. Interstitial Nephritis | |
| Due to ✓ | |
| Other conditions (Include pregnancy within 3 months of death) ✓ | |

Major findings:
Of operations no
Of autopsy no

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 E. A. Scott (M. D. or other)
Address St James Hospital St James Mo Date signed 12/26/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 14152
Date Filed

**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 S. C. [illegible]

Licensed Embalmer No. 3397

P. O. Address Rolla 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.**

S. No. 2B
0—4-25-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 42493

Registration District No. 677 Primary Registration District No. 4403 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Phelps
(b) City or town Rolla
(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) Citizen of foreign country (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas J. Stivens
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 Single
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 87 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)
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) 6-21-41 (Date received local registrar) (b) Jos. F. Green (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23 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.

| | Duration |
|---|---|
| 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? (Specify type of place)
While at work?
(e) Means of injury
23. Signature E. A. Scott (M. D. or other)
Address St James Mo Date signed

SUPPLEMENTARY

S-43493