

1. PLACE OF DEATH:
 (a) County Cape Girardeau
 (b) City or town Cape Girardeau
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Francis Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
 (Specify whether
 In this community Lifetimes
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Bellingham
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Near Scopus, Mo.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 1 years.

3. (a) PRINT FULL NAME HESTER ZEDA STEVENS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Geo. Stevens 6. (c) Age of husband or wife if alive 34 years
 7. Birth date of deceased Dec 17 1911
 (Month) (Day) (Year)

8. AGE: Years 29 Months 3 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Bellingham Co. Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Oscar Welch

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

14. Maiden name Hellie Pierce

15. Birthplace Bellingham Co. Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant George Stevens
 (b) Address Scopus, Mo.

17. (a) Burial (b) Date thereof Jan 25 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. James Cem. Scopus, Mo.

18. (a) Signature of funeral director Baker Funeral Home
 (b) Address Centralville, Mo.

19. (a) 1-23-41 (b) Jim Thompson
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 1 day 23
 year 41 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 1-22 1941, to 1-23 1941, that I last saw him alive on 1-22 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Encephalitis
OR ORGBRAH MENINGITIS

Due to influenza?

Due to _____

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

Major findings: Of operations _____ Of autopsy ORGBRAH COMPOSITION

Duration _____
 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? 101

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

23. Signature A. D. Smith (M. D. or other) _____
 Address Cape Girardeau Date signed 1/23/41

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

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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 J. E. Graham

Licensed Embalmer No. 4010

P. O. Address Luttrell, Va.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2066

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 125-

Primary Registration District No. 3009

Registrar's No. _____

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

1. PLACE OF DEATH:
 (a) County Cape Girardeau
 (b) City or town Cape Girardeau
 (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)

3. (a) PRINT FULL NAME Hester Zeda Stevens
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 29 Months 3 Days 6 If less than one year _____ 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 _____ (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) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH Month Jan day 23 year 1944 hour _____ minute _____ N.
21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Encephalitis
Cerebral meningitis

Due to _____
 Due to Influenza
(with Epidemic)

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

Major findings: Of operations _____
 Of autopsy Cerebral congestion

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? _____

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

23. Signature [Signature] (M. D. or other) _____
 Address Cape Girardeau Date signed _____

SUPPLEMENTARY

MO

