S. No. 2
-11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 15 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

24808

State File No. ____

Registration District No. 156 | Primary Registration District No. 5220 | Registrar's No. 41

1. PLACE OF DEATH:

(a) County: Cass

(b) City or town: Rural — Peculiar Twp. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Cass County Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 72 yrs 2 (Specify whether years, months or days)

In this community 72 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Cass 019

(c) City or town: Rural (If outside city or town limits, write "RURAL")

(d) Street No.: Cass Co Home (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

8. (a) PRINT FULL NAME: Emma Jane Stevens

8. (b) If veteran, name war: ____

8. (c) Social Security No.: ____

4. Sex: Fe 1

5. Color or race: Wh.

6. (a) Single, widowed, married, divorced: W. 2

6. (b) Name of husband or wife: deceased

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

7. Birth date of deceased: May (Month) 18 (Day) 1868 (Year)

8. AGE: Years 72 | Months 2 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace: Lonetree (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: ____

11. Industry or business: ____

FATHER 12. Name: Marion Stevens

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

MOTHER 14. Maiden name: Sarah Lewis

MOTHER 15. Birthplace: Illinois (City, town, or county) (State or foreign country)

16. (a) Informant: Ed Stevens

(b) Address: Harrisonville Mo.

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

(c) Place: burial or cremation: Orient Cem.

18. (a) Signature of funeral director: Atkinson Bros

(b) Address: Harrisonville Mo.

19. (a) July 22, 1941 (Date received by local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1941 hour 11:00 minute A M.

21. I hereby certify that I attended the deceased from July 20 1941, to July 21 1941, that I last saw her alive on July 20 1941, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Apoplexy — Duration

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. M. Leffler (M. D. or other) D

Address: Harrisonville Date signed 7/22/41

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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
M—8-21-41
I X29288

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. 24808

Registration District No. 156 Primary Registration District No. 5220 Registrar's No. 41

1. PLACE OF DEATH:

(a) County: Cass

(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Cass Co. Home
(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: Emma J. 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: Wid

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 | 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 July 23, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) 9/11/41 (Date received local registrar) (b) E. Wensley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 21 year 1941 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	Duration
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? .....

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

23. Signature ..... (M. D. or other)

Address ..... Date signed .....

SUPPLEMENTARY

S-24808