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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. 24855

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. 90

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs
(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

In this community about 9 days 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 999

(a) State Kansas (b) County 14

(c) City or town Wellsville 0
(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 2

3. (a) PRINT FULL NAME Charles Aredore Stevenin

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Hattie

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased Dec (Month) 15 (Day) - 1875 (Year)

8. AGE:

Years	Months	Days	If less than one day
65	7	24	hr. min.

9. Birthplace Carlson (City, town, or county) Nevada (State or foreign country)

10. Usual occupation Merchant

11. Industry or business Grocery

FATHER
12. Name Martin Stevenin
13. Birthplace (City, town, or county) France (State or foreign country)

MOTHER
14. Maiden name Emma Peters
15. Birthplace (City, town, or county) Iowa (State or foreign country)

16. (a) Informant Chas Stevenin Jr.

(b) Address Wellsville Kansas

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-9-41 (Month) (Day) (Year)

(c) Place: burial or cremation Wellsville Kansas

18. (a) Signature of funeral director Claude Prichard

(b) Address Excelsior Springs Mo.

19. (a) July 11-1941 (Date received local registrar) (b) Mrs Rea McCracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9th - 1941
year 1941 hour one minute 50 P.M.

21. I hereby certify that I attended the deceased from June 30, 1941, to July 9, 1941;
that I last saw him alive on July 9, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to 94 W

Due to

Other conditions arthritis, high blood sugar
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No.

(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 S. R. McCracken (M. D. or other) MD.

Address Excelsior Springs Mo Date signed 7/9/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-5-41

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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. Claude Buchanan

Licensed Embalmer No. 2751

P. O. Address Excelsior Springs Mo

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.