No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 5 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25169

Regis District No. 318 Primary Registration District No. 5440 Registrar's No. 600

1. PLACE OF DEATH:
(a) County GREENE 0
(b) City or town Springfield - D Campbell Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: MEDICAL CENTER FOR FEDERAL PRISONERS,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Mos. 7 Days (Specify whether years, months or days)
In this community 2 Months 7 Days. 2

39
0
0

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County Dyer, 039
(c) City or town Bogata, 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME STEPHENSON, Charlie
3. (b) If veteran, name war None
3. (c) Social Security No. Unknown
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Widower 1
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive Dec years
7. Birth date of deceased February (Month) 19, (Day) 1878 (Year)

8. AGE: Years 63 Months 5 Days 2 If less than one day hr. min.

9. Birthplace Bogata, (City, town, or county) TEXAS 1 (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
MOTHER FATHER
12. Name William Stephenson
13. Birthplace Unknown (City, town, or county) Indiana (State or foreign country)
14. Maiden name Jane Wilson,
15. Birthplace Unknown (City, town, or county) Texas (State or foreign country)
16. (a) Informant Deceased
(b) Address
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof July 21 (Month) 1941 (Day) (Year)
(c) Place: burial or cremation Bogata, Texas
18. (a) Signature of funeral director Chiene
(b) Address Springfield, Mo.
19. (a) 7-21-41 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)
764 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21, year 1941 hour 6 minute 15 A. M.
21. I hereby certify that I attended the deceased from May 14, 1941, to July 21, 1941, that I last saw him alive on July 21, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Sarcoma (Malignant fibro-sarcoma) — Duration Unknown
Due to
Due to
Other conditions: Arteriosclerosis Generalized — Unknown
(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 [illegible] (M. D.) D
Address Springfield, Missouri, Date signed
Clinical Director

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

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 R H Thieme

Licensed Embalmer No. 3681

P. O. Address Springfield, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25169

Registration District No. 318 Primary Registration District No. 5440 Registrar's No. 600

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(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 years, months or days)

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 Charlie Stephenson

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 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 63 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 (Month) (Day) (Year)
(c) Place: burial or cremation

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
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 Sarcoma (Malignant fibro-sarcoma) Primary seat (5th rib, right) in chest wall.

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

55e

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)
(b) 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 (M. D. or other)
Address Date signed

Unknown Springfield Mo

S-25169