MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

FILED OCT 3 1941

Do not use this space.

1. PLACE OF DEATH

County: Cass — Registration District No.: 147

Township: Everett — Primary Registration District No.: 5211

City: ..... (No. ..... St. ..... Ward)

File No.: 31301

Registered No.: .....

2. FULL NAME Howard H. Stubblefield

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ethel B. Stubblefield

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 23 - 1896

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ...hrs. or ....min.
	32	—	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Cass Co Mo.

PARENTS

10. NAME OF FATHER William Stubblefield

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tenn

12. MAIDEN NAME OF MOTHER Mattie Goodbar

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Virginia

14. INFORMANT Mrs Stubblefield
(Address) Freeman, Mo.

15. FILED 10-2 1941 Mrs. Dora Adair
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 24 1928

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1928, to April 24, 1928, that I last saw him alive on April 24, 1928, and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Influenza
33B
(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (SECONDARY) Chronic Arthritis
(duration) 6 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Isaac N Parrish M.D.
Apr 25 1928 (Address) Freeman Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Freeman — DATE OF BURIAL: 4/26 1928

20. UNDERTAKER: Reminenburger Bros (Co) — ADDRESS: Harrisonville

OCT 2 4 1997

No. 2B
-8-21-41
X29268

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. 31301

Registration District No. 147 Primary Registration District No. 5211 Registrar's No.

1. PLACE OF DEATH:

(a) County Cass

(b) City or town Rural Everett Twp.
(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 Mo (b) County Cass

(c) City or town Rural Everett Twp.
(If outside city or town limits, write "RURAL")

(d) Street No. North west of North & South west of Harrisonville Mo (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Howard H. Stubblefield

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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 (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

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) 11-4-41 (Date received local registrar) (b) Mrs Dora Adair (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 24
year 1928 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.

	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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-31301 1941