DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 16 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 52279

Registration District No. 682 Primary Registration District No. 4406 Registrar's No. 266

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

1. PLACE OF DEATH:

(a) County Pike

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

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

(d) Length of stay: In hospital or institution ..... (Specify whether

In this community 48 yrs. (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ~~Pike~~ MO (b) County Pike 682

(c) City or town Ashburn (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 0

3. (a) PRINT FULL NAME Rose E Stephens

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 Widow

6. (b) Name of husband or wife Wm Sam 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Nov. (Month) 2 (Day) 1869 (Year)

8. AGE: Years 72 Months 10 Days 20 If less than one day ..... hr. ..... min.

9. Birthplace — (City, town, or county) MO (State or foreign country)

10. Usual occupation House wife

11. Industry or business .....

FATHER 12. Name W. S. Egelston ~~Unknown~~

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 Lewis Stephens

(b) Address Ashburn MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Ashburn MO

18. (a) Signature of funeral director James O'Donnell

(b) Address Hannibal MO

19. (a) 9/27/41 (Date received local registrar) (b) G. Lewis Stephens (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 22 year 1941 hour ..... minute 1450 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 Cerebral Trombosis Fractured Hip Femur

Due to arteriosclerosis

Due to .....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations no

Of autopsy no

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) no

(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. Hardesty M.D. (M. D. or other)

Address Hannibal MO Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

614

RECEIVED
District Health Officer No. 10
District File No. 10-41-1796
Date Filed OCT 8 1941

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 Michael J O'Connell

Licensed Embalmer No. 3246

P. O. Address Hannibal Mo

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

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

No. 2B
—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. 32279

Registration District No. 682 Primary Registration District No. 4406 Registrar's No.

1. PLACE OF DEATH:
(a) County: Pike
(b) City or town: Ashburn
(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 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: Rose E. Stephens
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: W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Nov (Month) 2, (Day) 1865 (Year)

8. AGE: Years 71 Months 10 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 Sept. day 22 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.

	Duration
Immediate cause of death: Cerebral Thrombosis	
Due to: fractured hip femur	
Due to: arteriosclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

186a
18

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 Farmland Mo Date signed

SUPPLEMENTARY