

Registration District No. 688

Primary Registration District No. 4412

Registrar's No. 24

1. PLACE OF DEATH: Pike
 (a) County _____
 (b) City or town Frankford
 (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 21 Days
 years, months or days)

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

3. (a) PRINT FULL NAME Calvin Leon Stevenson

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec day 1
 year 1941 hour 1 minute 30 A. M.

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 0

21. I hereby certify that I attended the deceased from Nov. 29, 1941, to Dec. 1, 1941, that I last saw him alive on Nov 29, 1941, and that death occurred on the date and hour stated above.

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

Immediate cause of death Bronchitis - pneumonia Duration _____

7. Birth date of deceased Nov 10 1941
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 21 If less than one day _____ hr. _____ min.

Due to _____
 Due to _____

9. Birthplace Frankford Missouri
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation _____

11. Industry or business _____

Major findings: Of operations _____

12. Name Amel Edward Stevenson

Of autopsy _____

13. Birthplace Versailles, Missouri
 (City, town, or county) (State or foreign country)

Underline the cause to which death should be charged statistically.

14. Maiden name Opal Crenshaw

15. Birthplace Peach Orchard, Ark.
 (City, town, or county) (State or foreign country)

16. (a) Informant Pauline Stevenson

(b) Address Frankford, Mo.

17. (a) Burial (b) Date thereof Dec 1, 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frankford, Mo.

18. (a) Signature of funeral director Willis J. Jones

(b) Address Frankford, Mo.

19. (a) Dec 7 - 41 (b) Mattie Unsell
 (Date received local registrar) (Registrar's signature)

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)

(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 W. J. Jones (M. D. or other) _____
 Address Frankford, Mo. Date signed 12/1/41

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

RECEIVED

District Health Officer No. 10

District File Number 1-42-45

Date Filed JAN 9 1942

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 Jane Fields Mequ

Licensed Embalmer No. 409B

P. O. Address Frankford, M

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42733**

Registration District No. **688**

Primary Registration District No. **4412**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Pike**
(b) City or town **Frankford**
(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 **Cabin L. Stevenson**

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 **s**

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

7. Birth date of deceased **Nov. 10 1941**
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day _____
year **1941** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
_____ 19____;
that I last saw him alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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)
(c) Means of injury _____

23. Signature **W. L. Stevenson** (M. D. or other) _____
Address **Frankford, Mo.** Date signed **3/12/42**

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-42733