

No. 2
9-4-41
17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23708

FILED AUG 14 1942

State File No. _____

Registration District No. _____

Primary Registration District No. 1001

Registrar's No. 209

1. PLACE OF DEATH:

(a) County Adair

(b) City or town "Rural" Pitts. town
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
6 Miles, South West of Kirksville
(If not in hospital or institution, write street number or location)

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

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

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

(d) Street No. "Rural R. R. # 6"
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mintie Ethel Stukey

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Joseph 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased Dec. 10 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>7</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Sewell

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

14. Maiden name Ann Tilsen

15. Birthplace England
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. Grover Stukey

(b) Address Kirksville, Mo.

17. (a) Burial (b) Date thereof 7-31-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stukey Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address Kirksville, Mo.

19. (a) 8/15/42 (b) Mrs. J. L. Wagner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
year 1942 hour 10 minute 00 a.m. / p.m.

21. I hereby certify that I attended the deceased from June 1st 1942 to July 29 1942
that I last saw her alive on July 29 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration 5 days

Due to Chronic debility 3 years

Due to Hypertrophic Arthritis

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

Major findings: None

Of operations _____

Of autopsy no 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? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature A. T. Rhoads (M. D. or other) _____
Address Kirksville, Mo. Date signed 7/30/42

10490 (Licensed Embalmer's Statement on Reverse Side)

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

OCT 9 1942

RECEIVED

District Health Officer No. 10

District File Number 8-42-1577

Date Filed AUG 12 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.....

Licensed Embalmer No. 4181

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with 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. *23706*

Registrar's No. *209*

Registration District No. *1*

Primary Registration District No. *5005*

1. PLACE OF DEATH:

(a) County *Adair*
(b) City or town *Rural*
(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 *Left*
years, months or days)

3. (a) PRINT FULL NAME *Mentel Ethel Stucky*

3. (b) If veteran, name war _____ 3. (c) Social Security No. *none*

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *M*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive *84* years

7. Birth date of deceased *Jan 10 1884*
(Month) (Day) (Year)

8. AGE: Years *78* Months *7* Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MO* (b) County *Adair*
(c) City or town *Rural*
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *July* year *1942* minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Hypostatic pneumonia (lobar)

Due to *Chronic debility*

Due to *Hypertrophic Arthritis*

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

Major findings: Of operations _____

Of autopsy *108*

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? _____

While at work? _____ (Specify type of place) Means of injury _____

23. Signature *A. J. Rhoads* (M. D. or other) _____

Address *Fairville, MO* Date signed *8/3/42*

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

MOTHER FATHER

SUPPLEMENTAL

OCT 9 1942