

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED SEP 14 1942  
Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 221

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 208 No. Liberty St.  
(If not in hospital or institution, write street number or location)

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

In this community no record  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) Massachusetts (b) County Middlesex <sup>499</sup>

(c) City or town Soull <sup>19</sup>

(d) Street No. 420 Speden St <sup>0</sup>  
(If rural, give location)

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

If yes, name country no <sup>2</sup>

3. (a) PRINT FULL NAME Samuel A. Stubbs

3. (b) If veteran, name war no record

3. (c) Social Security No. no record

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 18  
year 1942 hour 7:45 minute a M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Aleena Stubbs 6. (c) Age of husband or wife if alive no record

7. Birth date of deceased: Sept 4 1890  
Month Day Year

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic occlusion of coronary arteries  
Chronic fibrous myocarditis

8. AGE: Years 51 Months 11 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death): 93d

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

10. Usual occupation Remington Arms Co.

MOTHER FATHER

12. Name no record

13. Birthplace no record  
(City, town, or county) (State or foreign country)

14. Maiden name no record

15. Birthplace no record  
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy see above

Underline the cause to which death should be charged statistically.

16. (a) Informant Grandeur Tom Stone

(b) Address Soull, Mass

17. (a) removal (b) Date thereof 8/18/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Soull, Mass

18. (a) Signature of funeral director Geo. C. Carson

(b) Address Independence, Mo.

19. (a) 8-18-42 (b) James W. Rose  
(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) (State)

(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. E. T. H. (M. D. or other) \_\_\_\_\_

Address K. C. Mo. Date signed 8/18/42

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

48  
4  
4

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**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

*Franker*

Licensed Embalmer No.

*2467*

P. O. Address

*Indep. Mo.*

**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.**