

FILED NOV 11 1942

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

Do not use this space.

35079

## 1. PLACE OF DEATH

108 County Demer Registration District No. 358 108  
0 Township ..... Primary Registration District No. 4524 0  
0 City Walker (No. ....) St. .... Ward) .....

File No. ....  
Registered No. 6  
St. .... Ward) .....

## 2. FULL NAME

William Jackson Stephens  
(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 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Rosa Stephens

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 15 - 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
84 11 16

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. retired Blacksmith

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....

10. Date deceased last worked at this occupation (month and year) 1934 11. Total time (years) spent in this occupation 20

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind. 0

13. NAME Leroy Stephens

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind. 1

15. MAIDEN NAME Nancy Rogers

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind. 1

17. INFORMANT Mrs Rosa Stephens  
(ADDRESS) Walker Ind

18. BURIAL, CREMATION, OR REMOVAL Int. Bur.  
PLACE Osage Cemetery DATE Oct 6 1942

19. UNDERTAKER Ferry Funeral Home  
(ADDRESS) Walker Ind.

20. FILED 10-6 1942 Antley Blum  
Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 5 1942

22. I HEREBY CERTIFY, That I attended deceased from Sept 20 1942 to Oct 5 1942

I last saw him alive on Oct 5 1942 Death is said to have occurred on the date stated above, at 9:30 a.m.

The principal cause of death and related causes of importance were as follows:

Strangulated Right Scrotal Hernia

Date of onset 1 year ago

Other contributory causes of importance: 127a

Name of operation ..... Date of .....  
What test confirmed diagnosis Plummet Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? .....  
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? yes  
If so, specify Hand work

(Signed) C. A. Davis, M. D.  
(Address) Walker Ind.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 7,

District File Number 11-42-1889

Date Filed 11-9-42

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35079  
Registrar's No. 6

Registration District No. 308 Primary Registration District No. 4524

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Walker  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)  
(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

3. (a) PRINT FULL NAME W. Jackson Stephens  
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 m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 19 (Month) (Day) (Year)

8. AGE: Years 84 Months 11 Days 19 (If less than one day, in min.)

9. Birthplace Mo. (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 \_\_\_\_\_ (State or foreign country)

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (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 VERNON  
(c) City or town WALKER (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

35079