

Registration District No. 275

Primary Registration District No. 30533939

Registrar's No. 3321

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town Rural .. Cold Springs Twp  
(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 Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Phelps

(c) City or town Rural .. Edgar Springs Star Rt  
(If outside city or town limits, write "RURAL")

(d) Street No. Cold Springs Township  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Ella Stogsdill

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female / Color or race Wh

5. Color or race Wh

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wesley Stogsdill

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 30, 1884  
(Month) (Day) (Year)

8. AGE: Years 58 Months 5 Days 18 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Robert Jones,

13. Birthplace Phelps Co., Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Denton,

15. Birthplace Phelps Co., Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Wesley Stogsdill

(b) Address Edgar Springs Star Route Rol

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rhea Cemetery

18. (a) Signature of funeral director Null & Son Funeral Home

(b) Address 508 West 8th St.,

19. (a) 2/21/43 (b) \_\_\_\_\_  
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 18 day 18 year 1943 hour 6 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Dec 15 1943 to Feb 18 1943; that I last saw her alive on Feb 18 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 10 hrs.

Due to 940

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

Other conditions Anemia (primary) 2 years  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

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

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

Of autopsy \_\_\_\_\_

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 E. E. Faid m. D. (M. D. or other) \_\_\_\_\_

Address Rolla mo. Date signed 2-21-43

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

21

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.....

*S. L. M. Reed*

Licensed Embalmer No.....

*3394*

P. O. Address.....

*Reed mmo*

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. 4249  
Registrar's No. 21

Registration District No. 275

Primary Registration District No. 2939

1. PLACE OF DEATH:

(a) County P helpe  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
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 Mary Ella Stogdill

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 m

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

7. Birth date of deceased Aug 20 1888  
(Month) (Day) (Year)

8. AGE: Years 58 Months 5 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

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

19. (a) \_\_\_\_\_ (b) Kellie Walker  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 03 Year 1943 hour \_\_\_\_\_ 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

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) (c) Means of injury \_\_\_\_\_

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

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

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

SUPPLEMENTARY

