Nc
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X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 12 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10590

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 70

1. PLACE OF DEATH:

(a) County: Jasper
(b) City or town: Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCune-Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3½ days (Specify whether years, months or days)
In this community 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jasper
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: Route 1, Golden City
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: - - -

3. (a) PRINT FULL NAME: Sarah Ellen Stone

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: John H. Stone

6. (c) Age of husband or wife if alive: - - years

7. Birth date of deceased: May (Month) 22 (Day) 1857 (Year)

8. AGE: Years 85 Months 9 Days 27 If less than one day hr. min.

9. Birthplace: Litchfield (City, town, or county) Illinois (State or foreign country)

10. Usual occupation: At Home

11. Industry or business: - -

FATHER
12. Name: Wade Roberts
13. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant: Claude W. Stone
(b) Address: Oklahoma City, Oklahoma

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 20, 1943 (Month) (Day) (Year)
(c) Place: burial or cremation: Dudenville, Mo.

18. (a) Signature of funeral director: Knell Mortuary
(b) Address: Carthage, Missouri

19. (a) Mch 20 '43 (Date received local registrar) (b) Elizabeth Coughlin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 19 year 1943 hour 920 minute A M.

21. I hereby certify that I attended the deceased from Mar 15 1943 to Mar 19 1943 that I last saw him alive on Mar 18 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia 4½ days
Chronic myocarditis

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death): Fracture rt hip - Mar 13

Major findings:
Of operations:

Of autopsy:

Duration

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): 029
(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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: H E Bird (M. D. or other)
Address: Carthage Mo Date signed 3-19-43

1203

(Licensed Embalmer's Statement on Reverse Side)

43-3-273

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 Emma L. Snell

Licensed Embalmer No. 391

P. O. Address Carthage

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

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

. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10590

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 70

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage
(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 Sarah Ellen Stone

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 W

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 22 (Day) 1857 (Year)

8. AGE: Years 85 Months 9 Days 21 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
year 1943 hour minute M.

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

Immediate cause of death Hypostatic pneumonia chronic myocarditis

Due to

Due to 186a 18

Other conditions
(Include pregnancy within 3 months of death)
Fracture of hip - Mar, 3

Major findings:
Of operations

Of autopsy

Duration 4 1/2 do

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) accident

(b) Date of occurrence Mar 13

(c) Where did injury occur? Lockwood (City or town) Dade (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place - (Specify type of place)

While at work? No (e) Means of injury Fall -

23. Signature H. E. Byrd MD (M. D. or other) M.D.

Address Carthage Mo Date signed 5-19-43