

No. 2
-5-42
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24638

FILED AUG 7 1943 57

Registration District No. 57

Primary Registration District No. 4086

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Tina, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home Tina, Missouri
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community 5 years..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll
(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 A

3. (a) PRINT FULL NAME CLAUDE S. STOFFER

3. (b) If veteran, name war NONE 3. (c) Social Security No. XX

4. Sex M. 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ida Stouffer
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 25th, 1870
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 25
If less than one day
.....hr.min.

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

10. Usual occupation Retired Groceryman

11. Industry or business.....

MOTHER FATHER
12. Name William Stouffer
13. Birthplace Pennsylvania
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Lewis
15. Birthplace Maryland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Claudine Henderson

(b) Address Tina, Missouri

17. (a) Burial (b) Date thereof 7/17/1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ebenezer, Bogard, Mo.

18. (a) Signature of funeral director Clifford W. Austin

(b) Address Tina, Missouri

19. (a) July 17-43 (b) Mr. S. Edgar Smith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16th
year 1943 hour 2:00 minute A. M.

21. I hereby certify that I attended the deceased from Dec 8th
1942 to July 16 1943;
that I last saw him alive on July 9th 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL
HEMORRHAGE

Due to HYPERTENSION

Due to ARTERIOSCLEROSIS

Other conditions CARDIAC FAILURE
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

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 R. W. MATHENY (M.D. or other) D.O.

Address Tina, Missouri Date signed 7-17-43

Duration

2-3 days

2-3 yrs.

12 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Clifford W. Austin,

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Clifford W. Austin

Licensed Embalmer No. 3233.

P. O. Address..... Tina, Missouri.

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.

Registration District No. 57 Primary Registration District No. 4086 Registrar's No. 16

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Tina
(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 mo (b) County Carroll
(c) City or town Tina
(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 Claude Stauffer

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 April 20
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days min.
If less than one day..... min.

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

10. Usual occupation.....

11. Industry or 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) July 17 43 (b) Mrs. Edgar Smith
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1943 hour 9 minute 46 M.

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

Due to.....
Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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?
..... (Specify type of place)

While at work?..... (e) Means of injury.....

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

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

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