

No. 2
5-42
17-39
X3287

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

File No. **32922**

FILED OCT 4 - 1943

Registration District No. **778**

Primary Registration District No. **4283**

Registrar's No. **79**

1. PLACE OF DEATH:

(a) County **Lewis**

(b) City or town **Ewing (Rural) Highland**
(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 **40 yr**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lewis** **56**

(c) City or town **Ewing (rural)**
(If outside city or town limits, write "RURAL") **0**

(d) Street No. _____ (If rural, give location)

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

If yes, name country _____ **0**

3. (a) PRINT FULL NAME **WILLIAM CAGOR STONE**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **15** year **1943** hour **7** minute _____ P.M.

21. I hereby certify that I attended the deceased from **Sept 15** 19**43** to **Sept 15** 19**43**
that I last saw him alive on **Sept 15** 19**43** and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, widowed **2 divorced, widowed**

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

7. Birth date of deceased **April 12 1886**
(Month) (Day) (Year)

Immediate cause of death **Concussive Agent Defense**
Abdominal thrombosis & Septicemic pneumonia

Due to _____

Due to _____

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

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

77 5 3 hr. _____ min.

9. Birthplace **WINTERVILLE MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **retired farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Jeremiah Stone**

13. Birthplace **Tennessee**
(City, town, or county) (State or foreign country)

14. Maiden name **Adeline - don't know**

15. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations _____

Of autopsy _____

16. (a) Informant **Mrs. Mabel Brown**

(b) Address **Ewing, Mo. R.I.**

17. (a) **burial** (b) Date thereof **Sept 17, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Durham**

18. (a) Signature of funeral director **Thomas BALL**

(b) Address **Ewing, Mo**

19. (a) **9-20-43** (b) **O. W. Jennings**
(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)

Means of injury _____

23. Signature **John D. Powers** (M. D. or other) **Dr. J. H. ...**

Address **Heversdown Mo** Date signed **9-17-43**

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

(Licensed Embalmer's Statement on Reverse Side)

APR 1 1958

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..... *Thomas Baell*
Licensed Embalmer No. *1744*
P. O. Address..... *Ewing, 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.

Registration District No. 178

Primary Registration District No. 5661

Registrar's No. 79

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

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Rural Highland
(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)

3. (a) PRINT FULL NAME Wm Cagor Stone

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. w

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

7. Birth date of deceased April 12 1884
(Month) (Day) (Year)

8. AGE: Years 77 Months Days In 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) (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) (Data received local registrar) (b) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15 year 1943 hour 1 minute 15 M.

21. I hereby certify that I attended the deceased from 11 to 11 1943; that I first saw him alive on 11 1943; and that death occurred on the date and hour stated above.

Immediate cause of death longestial heart failure (Lobar) Duration

Due to Cerebral Thrombosis & suppurative pneumonia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 108

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

32022