

S. No. 2
DM-44
7-5-37
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22587

NOV 1 1943

State File No.

Registration District No. **1318**

Primary Registration District No. **1003**

Registrar's No. **9418**

1. PLACE OF DEATH:

(a) County.....
(b) City or town **3911 Botanical Ave**
(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 **Missouri** (b) County **000**
(c) City or town **3911 Botanical Ave**
(If outside city or town limits, write "RURAL")
(d) Street No. **St. Louis**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country..... **0**

3. (a) PRINT FULL NAME **Dr. James Preston Stubblefield**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **25**
year **1943** hour **1** minute **5** P.M.

3. (b) If veteran, name war..... 3. (c) Social Security No. **None**

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

21. I hereby certify that I attended the deceased from **10/24** 19**43** to **only** 19**43**
that I last saw him alive on **10/24** 19**43**
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **April 2 1855**
(Month) (Day) (Year)

Immediate cause of death.....
Uremia

8. AGE: Years **88** Months **6** Days **23** If less than one day
..... hr. min.

Due to **Chronic nephritis**
Due to **Advanced arteriosclerosis**

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

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

10. Usual occupation **Medical Doctor**

Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business.....

12. Name **J. Preston Stubblefield**

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

14. Maiden name **Nancy Ann Grasshan**

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

16. (a) Informant **Miss Beulah Stubblefield**

(b) Address **3911 Botanical**
17. (a) **Burial** (b) Date thereof **Oct. 28, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
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?

18. (a) Signature of funeral director **Wm J. Robert L. & Co.**

(b) Address **1905 South Grand St. St. Louis, Mo.**

19. (a) **OCT 26 1943** (b) **J. Bredeck**
(Data received local registrar) (Registrar's signature)

23. Signature **Wm J. Robert L. & Co.** (Specify type of place) (b) Means of injury.....
Address **3107 So. Grand** Date signed **10/25/43**

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

John Fetter
.....
Licensed Embalmer No. 3880

P. O. Address:.....

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.