

34948

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 147

Primary Registration District No. 5569

Registrar's No. 135

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Raytown
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 9210 E 65th
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 9 months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson ⁴⁸

(c) City or town Raytown ⁰
(If outside city or town limits, write "RURAL")

(d) Street No. 9210 E 65th
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years ⁰

3. (a) PRINT FULL NAME Philip Hale Stevenson

3. (b) If veteran, name war no

3. (c) Social Security No. 227-12

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 24 year 43 hour 12:45 minute AM 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.

4. Sex male 5. Color or race White

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

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

7. Birth date of deceased Oct - 24 - 1942
(Month) (Day) (Year)

Immediate cause of death Thyroid hyperplasia
Stasis thymus-lymphatics

Due to 64

Other conditions (Include pregnancy within 3 months of death)

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

0	9	8	
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hr. _____ min. _____

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

Due to _____

Major findings: See above

Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

10. Usual occupation _____

11. Industry or business _____

12. Name Hale H. Stevenson

13. Birthplace Fairfield Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Charlotte Derry

15. Birthplace Morehead Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Hale H. Stevenson

(b) Address P.O. #3, N.C. Mo.

17. (a) Cremation (b) Date thereof Aug 3 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chunwood Cemetery N.C. Mo.

18. (a) Signature of funeral director E. Clark

(b) Address Raytown Mo.

19. (a) Aug 3 1943 (b) Mrs P. P. Jarvin
(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)

(e) Means of injury _____

23. Signature [Signature] 3 [Signature]
Date signed [Signature]

MOTHER FATHER

Hair Blond
Blue eyes
Stigmata large. 25 years.

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..... *E. Clark Regent*

Licensed Embalmer No. *3983*

P. O. Address *Raytown, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7205

Registration District No. 147

Primary Registration District No. 5569

Registrar's No. 125

1. PLACE OF DEATH

(a) County Jackson
(b) City or town RURAL - BROOKING
(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 Philip H. Stevens

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 S

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased Oct. 24 1918
(Month) (Day) (Year)

8. AGE: Years Months Days 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) (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) [Signature] (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 April day 12 year 1948 hour..... minute..... 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..... 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) (e) Means of injury.....

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

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

SUPPLEMENTARY

MOTHER FATHER

3494b