

FILED MAY 8 1944

Registration District No. _____

Primary Registration District No. 3021

Registrar's No. 35

1. PLACE OF DEATH:

(a) County HOWELL
(b) City or town WEST PLAINS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
CHRISTA HOGAN HOSP.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 DAYS (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State ARKANSAS (b) County FULTON
(c) City or town VIOLA
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM JACOB STONE

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

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife ETTA STONE
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased SEPT. 12, 1863
(Month) (Day) (Year)

8. AGE: Years 80 Months 5 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace IZARD CO, ARKANSAS
(City, town, or county) (State or foreign country)

10. Usual occupation FARMING

11. Industry or business.

MOTHER FATHER { 12. Name NICHOLAS P. STONE
13. Birthplace TENN.
(City, town, or county) (State or foreign country)
14. Maiden name SARAH JANE FRANKS
15. Birthplace ARK.
(City, town, or county) (State or foreign country)

16. (a) Informant A.C. STONE
(b) Address WEST PLAINS, MO.

17. (a) REMOVAL (b) Date thereof APR. 7, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
MT. CALM CEM. FULTON CO., ARK.
(c) Place: burial or cremation

18. (a) Signature of funeral director Hal Thompson
(b) Address WEST PLAINS, MO.

19. (a) 4-10-44 (b) Paul [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4
year 1944 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from April 1, 1944 to April 4, 1944
that I last saw him alive on April 4, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chc Myocarditis

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?

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) MD
Address West Plains, Mo. Date signed 4-5-44

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

16
1
1

1125

RECEIVED

District Health Officer No. 5,

District File Number 444269

Date Filed 9-6-44

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 Hal Homburg

Licensed Embalmer No. 3408

P. O. Address West Plains, 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.