

FILED MAY 11 1944

Registration District No. 20Primary Registration District No. 5721

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County Macou  
 (b) City or town Macou  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Still-Hildreth Posteo. Sav.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4-10-44 (11:30 AM)  
to 4-14-44 (8:52 AM) (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT  
FULL NAMECoval Stephen3. (b) If veteran,  
name war None3. (c) Social Security  
No. 491-22-54794. Sex Male 5. Color or  
race White 6. (a) Single, widowed, married,  
divorced 16. (b) Name of husband or wife Mrs. Coval Stephen 6. (c) Age of husband or wife if  
alive 34 years7. Birth date of deceased 11 14 09  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
37 3 hr. \_\_\_\_\_ min.9. Birthplace Hill City Kansas  
(City, town, or county) (State or foreign country)10. Usual occupation Filling Station Attendant11. Industry or business Howard HawkinsMOTHER FATHER { 12. Name Ira Stephen13. Birthplace Kansas  
(City, town, or county) (State or foreign country)14. Maiden name Viola Steinbolt15. Birthplace Unknown  
(City, town, or county) (State or foreign country)16. (a) Informant Nadine Stephen (Wife)(b) Address 6605 Carnegie St.  
Burial (b) Date thereof 4/18/44(c) Place: burial or cremation I.O.O.F. Cemetery18. (a) Signature of funeral director John E. Grupp(b) Address 6054 Pryor Ave., City19. (a) \_\_\_\_\_ (b) 1037 Registrar's signature  
(Date received local registrar)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11  
 (c) City or town St. Joseph 7  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 6605 Carnegie  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14  
year 1944 hour 8 minute 52 A.M.21. I hereby certify that I attended the deceased from April  
10, 1944 to April 14 1944  
that I last saw him alive on 4/14 1944  
and that death occurred on the date and hour stated above.Immediate cause of death hepat. Pneu-  
Monia with Acetated  
depression Duration \_\_\_\_\_

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)  
(c) Means of injury \_\_\_\_\_23. Signature Frank H. Grupp (M. D. or other) 100  
Address Macou Mo. Date signed 4/17/44

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

**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, ~~only~~.....

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

Signed

*John E. Rupp*

Licensed Embalmer No. *3986*

P. O. Address *H. Joseph, M.*

**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. May  
Registrar's No. \_\_\_\_\_

Registration District No. 200 Primary Registration District No. 0725

1. PLACE OF DEATH:  
(a) County Madison  
(b) City or town Anderson Twp.  
(c) Name of hospital or institution: St. Hedwig's Hospital  
(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 Coral Stephen  
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 11 1907  
(Month) (Day) (Year)

8. AGE: Years 37 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Carson  
(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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 5/15/44 (b) Jara B. Finkler  
(Date received local registrar) (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 \_\_\_\_\_ Year 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 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)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_

SUPPLEMENTAL

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

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