

FILED AUG 18 1944

Registration District No.

Primary Registration District No.

5135

Registrar's No.

244

## 1. PLACE OF DEATH:

(a) County Butler  
 (b) City or town Rural Broseley  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Route 1 Ash Hill Camp  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 40 years years, months or days)

3. (a) PRINT FULL NAME James W. Stoker3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Ruth Stoker  
 6. (c) Age of husband or wife if alive 42 years  
 7. Birth date of deceased April 1, 1877  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>3</u>	<u>18</u>	hr. _____ min.

9. Birthplace Tennessee  
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business

12. Name Almon Stoker13. Birthplace Tennessee  
(City, town, or county) (State or foreign country)14. Maiden name Prudy Turner15. Birthplace Tennessee  
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. Jas. W. Stoker(b) Address Rt. 1, Broseley17. (a) Burial (b) Date thereof July 20 '44  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mole Hill Cemetery18. (a) Signature of funeral director Greer Croy(b) Address Poplar Bluff, Missouri19. (a) 7-28-44 (b) Belle Stinson  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler 12  
 (c) City or town Rural - Broseley 0  
 (If outside city or town limits, write "RURAL") 0  
 (d) Street No. Route 1  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country D

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19  
year 1944 hour 6 minute 45 A.M.21. I hereby certify that I attended the deceased from Mar. 1944 to 7-19, 1944  
that I last saw him alive on July 6, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death

Tuberculosis ✓

Duration

Unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

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

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)

(g) Means of injury \_\_\_\_\_

23. Signature J. W. Jones (M. D. or other)  
Address Poplar Bluff, Mo. Date signed 7-27-44

RECEIVED

District Health Office No

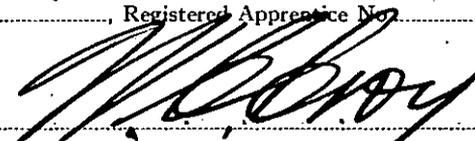
District File Number 844-1

Date Filed 8-3-44

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

working under my personal supervision.

Signed 

Registered Apprentice No.  
Licensed Embalmer No. 3474

P. O. Address Poplar Bluff, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. Aug

Registration District No. 43

Primary Registration District No. 5135

Registrar's No. 2440

1. PLACE OF DEATH:  
(a) County: Butler  
(b) City or town: Rural Ash Hill Sup  
(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: James W. Stokes  
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 \_\_\_\_\_ Year

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

8. AGE: Years 61 Months 3 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace: \_\_\_\_\_ (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 \_\_\_\_\_ (Month) (Day) (Year)

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

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

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (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 July Day 19 Year 1944 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: tuberculosis pulmonary, bilateral, all lobes. Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTAL**

MOTHER FATHER

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

24238