

FILED AUG 8 1944
Registration District No. 2096

Primary Registration District No. 575-2

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

1. PLACE OF DEATH:

(a) County Madison
 (b) City or town Rural Twelve mile Dump
 (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) 1
 (d) Length of stay: In hospital or institution _____
 In this community Life years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison
 (c) City or town Rural (If outside city or town limits, write "RURAL") 6200
 (d) Street No. Twelve mile Dump (If rural, give location) 0
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country U

3. (a) PRINT FULL NAME WILLIAM HENRY STEVENS
 (b) If veteran, name war no (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9 year 1944 hour 6 minute 30 A. M.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Martha Elizabeth Stevens live 80 years (c) Age of husband or wife if
 7. Birth date of deceased May 27 1863 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar 10, 1944, to July 9, 1944
 that I last saw him alive on Mar 10, 1944, and that death occurred on the date and hour stated above.
 Immediate cause of death Acute Slemia Duration 6.200

8. AGE: Years 81 Months 1 Days 12 If less than one day _____ hr. _____ min.

Due to _____
 Due to _____

9. Birthplace Madison Co MO (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Farming

Major findings: 92a
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Hosea Stevens
 13. Birthplace Madison Co MO (City, town, or county) (State or foreign country)

14. Maiden name Catherine F. ...
 15. Birthplace Tenn (City, town, or county) (State or foreign country)

16. (a) Informant Alonia von Sterberg
 (b) Address Tion, Missouri

17. (a) Burial (b) Date thereof July 10 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Mr. Pasqua Cemetery

18. (a) Signature of funeral director Walter Hall ...
 (b) Address Fred ...

19. (a) July 9 1944 (Date received local registrar) (b) S. A. ... (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?
 _____ (Specify type of place)
 While at work? _____ (e) Means of injury 0

23. Signature O. P. Myers (M. D. or other) _____
 Address Coldwater Mo Date signed 7/9/44

RECEIVED

District Health Officer No. 4
District File Number 844-4047
Date Filed 8-5-44

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

John A. Holt

Licensed Embalmer No. 4264

P. O. Address Fredericktown, 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.