

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

30954
Do not use this space.

FILED OCT 13 1944

1. PLACE OF DEATH

(a) County Greene Registration District No. 128
 (b) Township S. Campbell Twp. Primary Registration District No. 5466 Registered No. 715A
 (c) City Springfield, Rural (City or Town) No. 02 ARK OSTEOPATHIC HOSPITAL St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. Mt. Grove, Missouri
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF None
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 1, 1944
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 0 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield, Mo.

FATHER 13. NAME Harley Hyle Stubbs
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atwood Colorado

MOTHER 15. MAIDEN NAME Edith Mae Lemons
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Norwood R2 Missouri

17. INFORMANT (ADDRESS) MR. J. Lemons Norwood, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Denlow Cem. DATE 9-5 1944

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. A. Craig Jr. Mt. Grove, Mo.

20. FILED 9-5 1944 W. H. Hanley Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 3, 1944

22. I HEREBY CERTIFY, that I attended deceased from Sept 1, 1944 to Sept 3, 1944
 I last saw him alive on Sept 3, 1944 Death is said to have occurred on the date stated above, at 5:15 A.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage Date of onset 9-1-44

Other contributory causes of importance: 1/60

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) W. A. Craig Jr. M. D.

(Address) Mountaineer Ave. Mo.

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.

X