

FILED OCT 9 1944  
Registration District No. 235

Primary Registration District No. 5877

State File No. \_\_\_\_\_  
Registrar's No. 77

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Alton Piney Twp.  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME William P. Stogsdill

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. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 31 1870  
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 17

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Oregon County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Walker Stogsdill

13. Birthplace Tenn.  
(City, town, or county) (State or foreign country)

14. Maiden name Emma Shields

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jesse Norman

(b) Address Alton, Mo.

17. (a) Burial (b) Date thereof 7/19/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cave Springs Cem.

18. (a) Signature of funeral director Leo Dan

(b) Address Trayer, Mo.

19. (a) 9/20/1944 (b) Therese M. [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75

(c) City or town Alton (Rural)  
(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 18  
year 1944 hour 2 minute 00 P. M.

21. I hereby certify that I attended the deceased from July 1  
1944 to July 18 1944  
that I last saw him alive on July 15 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure  
General Atherosclerosis  
Senility

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)

(a) Means of injury C

23. Signature Dr. Charles M.D. (M. D. or other)

Address 14 [Address] Date signed 8-8-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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**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, fact should be so stated above.**