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M-8-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12993
Registrar's No. 30

FILED APR 23, 1945
Registration District No. 70

Primary Registration District No. 4065

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

1. PLACE OF DEATH:
(a) County Caldwell
(b) City or town Polo
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Albion life years, months or days)

3. (a) PRINT FULL NAME Rachel Ann Stone
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Wh
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Tom Stone 6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased April 10 1959 (Month) (Day) (Year)

8. AGE: Years 85 Months 11 Days 17 If less than one day hr. _____ min. _____

9. Birthplace Caldwell Co. Mo (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Jesse K. Flint
13. Birthplace Ohio (City, town, or county) (State or foreign country)
14. Maiden name Amanda Alvord
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Verna Albright
(b) Address Polo Mo

17. (a) Burial (b) Date thereof 4-29-45 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cowley Mo

18. (a) Signature of funeral director Albright Cowley
(b) Address Polo Mo

19. (a) April 4 1945 (b) Corinn Jarrett (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Caldwell
(c) City or town Polo 13 (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27 year 1945 hour 2 minute 20 P M.
21. I hereby certify that I attended the deceased from Aug 10 1943, to 3-27 1945, that I last saw him alive on 3-27 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration _____

Due to Hypertension

Due to Nephritis

Other conditions Carcinoma ? (Include pregnancy, within 3 months of death)
Stomach

Major findings: Of operations _____ Of autopsy H&H 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) no
(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 Ch Wilson M.D. (Physician or other) Address Polo Mo Date signed 3-28-45

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.