

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 11 1945
Registration District No. 354

Primary Registration District No. 4519

Registrar's No. 91

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

1. PLACE OF DEATH:

(a) County TEXAS

(b) City or town CABOOL
(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 years, months or days)

In this community 37 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Texas

(c) City or town Cabool
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Hubert Leo Stogsdill

3. (b) If veteran, name war _____

3. (c) Social Security No. 495-10-8200

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29
year 1945 hour 10 minute 25 a. M.

4. Sex ma 5. Color or race W.

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife CAROLINE

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Aug 10 1910
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 1 1945 to Apr 29 1945
that I last saw him alive on Apr 29 1945
and that death occurred on the date and hour stated above.

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|-----------|----------------------|
| <u>34</u> | <u>8</u> | <u>19</u> | hr. _____ min. |

Immediate cause of death Mitral Insufficiency

Duration 5 yr

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

Due to _____

Due to _____

10. Usual occupation LABORER

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 92K

Of autopsy _____

MOTHER FATHER

11. Industry or business _____

12. Name LEE Stogsdill

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

14. Maiden name ROSE Butts

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Leo Stogsdill

(b) Address Cabool Mo.

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? _____

17. (a) Burial (b) Date thereof May 4 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cabool

While at work? _____ (Specify type of place) (c) Means of injury _____

18. (a) Signature of funeral director Gaylord Elliott

(b) Address Cabool Mo.

19. (a) May 4-1945 (b) Mrs. Lou Miller
(Date registered local registrar) (Registrar's signature)

23. Signature M. E. Eddis (M. D. or pharmacy)
Address Cabool Mo. Date signed May 1 45

RECEIVED

District Health Officer No. 5,

District File Number 545-240

Date Filed 5.10.45-

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 Taylor Vellitt

Licensed Embalmer No. 2252

P. O. Address Cabool 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.