

JUL 9 1945
Registration District No. **1232**

Primary Registration District No. **5114**

Registrar's No. **62**

1. PLACE OF DEATH:

(a) County **Bellinger**
(b) City or town **Rural Wayne**
(c) Name of hospital or institution: **1 - 1/2 mi. S.?**
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Bellinger**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **17**
year **1945** hour **9** minute **300** M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Senility** Duration _____
Due to _____

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: **162K**
Of operations _____
Of autopsy _____

PHYSICIAN

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) _____
(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 **E. C. Masters** (M. D. or other) **MD**
Address **Adrian, Mo.** Date signed **6/17/45**

3. (a) PRINT FULL NAME **Virginia Ann Stebb**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 1. Color or race **W** 2. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **May 9 1868**
(Month) (Day) (Year)

8. AGE: Years **77** Months **11** Days **8** If less than one day _____ hr. _____ min.

9. Birthplace **Greenbrier Mo** 1.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business **House work**

12. Name **Nathan G. Cato**

13. Birthplace **Ark** 1.
(City, town, or county) (State or foreign country)

14. Maiden name **Popp. Cato**

15. Birthplace **Mo. Defa** 0
(City, town, or county) (State or foreign country)

16. (a) Informant **Wm. Cato**

(b) Address **Greenbrier Mo**

17. (a) **Burial** (b) Date thereof **4-19-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cato Cemetery**

18. (a) Signature of funeral director **Walter Serrice**

(b) Address **Waynes, Mo**

19. (a) **June 14 1945** (b) **Mrs. Geneva Mahan**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

1063

RECEIVED

District Health Officer No. 4
District File Number 745-785
Date Filed 2-6-45

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..... *Lynnan Steele*.....
Licensed Embalmer No. 2476
P. O. Address..... *Nexter 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 63

Registration District No. 22

Primary Registration District No. 5114

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

1. PLACE OF DEATH:

(a) County Bollinger

(b) City or town Rural Wayne 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)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Virginia A. Stepp

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

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

6. (b) Name of husband or wife (James Stepp)

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 77 Months _____ Days _____
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(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 17
Year 1965 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

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) _____

(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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

S-19826