

FILED SEP 21 1945

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **198**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Ellis Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Adair**
(c) City or town **Kirksville**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.R. # 7**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

James Gabriel Stephens

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 **single**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 13, 1864**
(Month) (Day) (Year)

8. AGE: Years **81** Months **5** Days **9**
If less than one day _____ hr. _____ min.

9. Birthplace **Monroe County Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Agriculture**

12. Name **Robert Stephens**
13. Birthplace **Ky**
(City, town, or county) (State or foreign country)
14. Maiden name **Jessie Hill**
15. Birthplace **Va**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Fyle Partin**
(b) Address **201 S. Halburton, Kirksville, Mo.**

17. (a) **Burial** (b) Date thereof **7-24-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Stuckey Cemetery**
18. (a) Signature of funeral director **Davis Funeral Home**
(b) Address **Kirksville, Mo.**

19. (a) **9-4-45** (b) **Mrs. J. B. Wagner**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **22**
year **1945** hour **3** minute _____ p. M.

21. I hereby certify that I attended the deceased from **July 18**
1945 to **July 22** 1945
that I last saw him alive on **July 22** 1945
and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar Pneumonia** Duration **4 days**

Due to _____
Due to _____

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

Major findings:
Of operations _____
Of autopsy **108**

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) Means of injury _____

23. Signature **R. R. Ellis** (M. D. or other)
Address **Kirksville, Mo.** Date signed **7-27-45**

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

RECEIVED

District Health Officer No. 10

District File Number 7-45-1457

Date Filed SEP. 19 1945

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

Beverly Beatty

Licensed Embalmer No.

4379

P. O. Address

Kirkville, 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.