S. No. 2
M—5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 16 1947

Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30983

Primary Registration District No. 5465

Registrar's No. 711F

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Rural (Campbell Twsp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Pleasant Hope R.F.D. #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 86 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk 84

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

(d) Street No. Pleasant Hope R.F.D. 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME America L. Stokes

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife James T. Stokes

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

7. Birth date of deceased May (Month) 7, (Day) 1861 (Year)

8. AGE: Years 86 Months 3 Days 2 If less than one day ..... hr. ..... min.

9. Birthplace Rose Hill, (City, town, or county) Missouri (State or foreign country)

10. Usual occupation House wife

11. Industry or business House wife

FATHER
12. Name Martin Best
13. Birthplace Kansas City, (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Martha Hart
15. Birthplace Pleasant Hope, (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Nomah Hall
(b) Address Pleasant Hope, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Brighton, Mo. Cemetery

18. (a) Signature of funeral director Fred C. Thieme
(b) Address Springfield, Mo.

19. (a) 8-13-47 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th year 1947 hour 8:00 P.M. minute ..... M.

21. I hereby certify that I attended the deceased from July 1, 1947 to Aug 9, 1947 that I last saw her alive on Aug 1, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cardio - Renal - Vascular Disease — Duration 2-3 yr.

Due to

Due to

Other conditions Fracture of right hip
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY INFORMATION REQUESTED

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 Mat Tetz (M. D. or other) MD

Address Springfield Mo Date signed 8-13-47

(Licensed Embalmer's Statement on Reverse Side)

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 Fred C. Phieno

Licensed Embalmer No. 2899

P. O. Address Springfield, 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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 128 Primary Registration District No. 5465 Registrar's No. 7111

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural
(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)

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

3. (a) PRINT FULL NAME America L. Staken

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 Wed

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 7 (Day) 1886 (Year)

8. AGE: Years 46 Months 3 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) 9-30-47 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug day 9
year 1947 hour minute 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

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death) 186 A

Major findings:
Of operations 18

Of autopsy

Duration

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) Accident

(b) Date of occurrence About July 1st 1947

(c) Where did injury occur? At home - Greene Co. Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
At Home
(Specify type of place)

While at work? No (e) Means of injury Fall

23. Signature Max Fitch (M. D. or other) MD

Address Springfield, Missouri Date signed

Dr. Max Fitch

SUPPLEMENTARY

S-30983