S. No. 2
—9-4-41
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 27 1947

Registration District No. 95

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5336

State File No. 34078

Registrar's No. 82

29
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0

1. PLACE OF DEATH:
(a) County: DADE
(b) City or town: RURAL — CENTER
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5 MILES EAST OF GREENFIELD.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: NONE (Specify whether years, months or days)
In this community: 83 YEARS.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: DADE
(c) City or town: RURAL
(If outside city or town limits, write "RURAL")
(d) Street No.: 5 MILES EAST OF GREENFIELD
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: No

3. (a) PRINT FULL NAME: JOHN L. STOCKTON
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: MALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: SINGLE
6. (b) Name of husband or wife: NONE
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: APRIL (Month) 22 (Day) 1864 (Year)

8. AGE: Years	Months	Days	If less than one day
83	5	20	hr. min.

9. Birthplace: DADE COUNTY (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: RETIRED FARMER
11. Industry or business: FARMER

FATHER
12. Name: GIPSON STOCKTON
13. Birthplace: NO RECORD (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name: REBECCA PATTERSON
15. Birthplace: NO RECORD. (City, town, or county) (State or foreign country) 9

16. (a) Informant: Mrs. Rosa J. Scott
(b) Address: R#1 Greenfield, Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 10-14-47 (Month) (Day) (Year)
(c) Place: burial or cremation: STOCKTON CEMETERY
18. (a) Signature of funeral director: Sam L. Sweeney Jr.
(b) Address: Greenfield, Mo.
19. (a) 10-15-47 (Date received local registrar) (b) Geo L. Weir (Registrar's signature) 70

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 12 year 1947 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from Oct 5, 1947, to Oct 12, 1947, that I last saw him alive on Oct 11, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial failure	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: DCA	
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: H. O. Cowan (M. D. or other)
Address: Greenfield Mo Date signed 10-14-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 1047-1097
Date Filed OCT 25 1947

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 Sam E. Sweeney Jr

Licensed Embalmer No. 4099

P. O. Address Greenfield, 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.