

FILED OCT 19 1948

Registration District No. 1

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3000

31863

State File No. _____

Registrar's No. 301

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:
Grim-Smith Hospital (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 _____
years, months or days

3. (a) PRINT FULL NAME Stephen Dean Douglas

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Oct. 15 1948
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	0	0	3 hr. 10 min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Wilford Dean Douglas

13. Birthplace Adair County, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Norma Louise Jones

15. Birthplace Adair County, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Wilford D. Douglas

(b) Address Kirksville, Mo.

17. (a) Burial (b) Date thereof 10/16/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pratt Cemetery

18. (a) Signature of funeral director Dee Riley Funeral Home

(b) Address Kirksville, Mo.

19. (a) 10-15-48 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. 1005 S. Sheridan
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15
year 1948 hour 10:00 minute A: M.

21. I hereby certify that I attended the deceased from Oct. 15
1948, to Oct. 15, 1948
that I last saw him alive on Oct. 15, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage, intracranial Duration 3 hours

Due to Brain delivery

Due to _____

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

Major findings: _____
Of operations 160
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)
(c) Means of injury 0

23. Signature [Signature] (M. D. or other) [Signature]
Address Kirksville, Mo. Date signed 10/16/48

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File Number 10-48-186
Date Filed OCT 18 1948

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 *Franklin*

Licensed Embalmer No. 4181

P. O. Address Kirksville, 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.