

S. No. 2
-11-10-39
5-17-39
-I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35412

State File No. _____

FILED NOV 5 1948
Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 143

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

1. PLACE OF DEATH:

(a) Courthouse _____

(b) City or town Person Wash. Hosp

(c) Name of hospital or institution: State Hospital 3. 2
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 2 1/2 yrs. 9 mos. 9 da.
(Specify whether In this community 3 1/2 yrs 7 mos 9 days years, months or days)

3. (a) PRINT FULL NAME ABRAHAM STEPHENSON

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 Married

6. (b) Name of husband or wife Ethel Stephens

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

7. Birth date of deceased 5-5-1905
(Month) (Day) (Year)

8. AGE: Years 43 Months 5 Days 16
If less than one day hr. _____ min. _____

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

10. Usual occupation Gate

11. Industry or business Herberg Stephens

12. Name Agnes Laura

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

14. Maiden name Devere Atchitt

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

16. (a) Informant Hospital record

(b) Address Nevada, Mo.

17. (a) Removal (b) Date thereof Oct. 21, 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Mo

18. (a) Signature of funeral director Martha Cullinger

(b) Address Nevada, Mo.

19. (a) 10-29-48 (b) W. Kathryn Nancy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene 39

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

(d) Street No. 2070 N. Douglas
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 21 year 1948 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from 10-16- 1948 to 10-21 1948
that I last saw him alive on Oct 21 1948
and that death occurred on the date and hour stated above.

Immediate cause of death encephalitis

Due to _____

Due to _____

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

Major findings: ✓
Of operations mb

Of autopsy _____

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 W. R. G. Hall (M. D. or other) _____

Address Nevada Mo Date signed 10-21-48

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7

District File Number 10-48-32

Date Filed 11-2-48

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.....

Max W. Beckering....., Registered Apprentice No. 278
working under my personal supervision.

Signed Mark E. Heiger

Licensed Embalmer No. 2656

P. O. Address Nevada, 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, above space should be left blank.