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

37213

State File No. 12-48-144

FILED DEC 8 1948

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 146

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Louise Wallace Hosp O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 4 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 15

(a) State Missouri (b) County Camden

(c) City or town Decatorville Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. Star Route 1
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Mat Stone

3. (b) If veteran, name war no

3. (c) Social Security No.

4. Sex Male O

5. Color or race Wht

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

6. (b) Name of husband or wife Sarah A Winfrey

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Dec (Month) 19 (Day) 1870 (Year)

8. AGE: Years 77 Months 10 Days 18 If less than one day hr. min.

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

10. Usual occupation farming

11. Industry or business

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

MOTHER
14. Maiden name Sarah Jane Claiborne
15. Birthplace Decatorville (City, town, or county) Mo O (State or foreign country)

16. (a) Informant Sarah Stone
(b) Address Decatorville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov (Month) 19 (Day) 48 (Year)
(c) Place: burial or ~~cremation~~ Union Cemetary

18. (a) Signature of funeral director Bankson-Woolvy
(b) Address Camdenton, Mo

19. (a) 11-30-48 (Date received local registrar) (b) Tressie B. Lynly (Registrar's signature) 0214

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Nov day 17
year 1948 hour 4 minute A M.

21. I hereby certify that I attended the deceased from 11/14, 1948, to 11/17, 1948, that I last saw him alive on 11/16, 1948, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Myocardial failure	2 dss.
Due to	
Due to	
Other conditions lung hemorrage (Include pregnancy within 3 months of death)	8 hrs

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 James L. Hope (M. D. ~~or other~~)
Address Lebanon, Mo Date signed 11/27/48.

(Licensed Embalmer's Statement on Reverse Side)

OCT 3 1949

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 Abie Bankson Woolery

Licensed Embalmer No. 2488

P. O. Address Camdenton, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—3-45
I X43880

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 170 Primary Registration District No. 3023 Registrar's No. 146

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(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 years, months or days)
In this community

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 Mat Stone
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec 14 (Month) (Day) (Year)
8. AGE: Years 77 Months 10 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1948 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	Duration
Due to Adenocarcinoma left lung	unknown
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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 James L. Hope (M. D. or other)
Address Lebanon, Mo Date signed 12/12/48

SUPPLEMENTARY

S-37213