WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Ray

Township: Camden
or
Village: Camden
or
City ______ (NO. ______ St.; ______ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 739 — File No. 27354

Primary Registration District No. 4441 — Registered No. ______

FULL NAME: Henry Stevenson

PERSONAL AND STATISTICAL PARTICULARS		
SEX: Male	COLOR OR RACE: Black	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: UK (Month) UK (Day), UK (Year)

AGE: About 58 yrs. ___ mos. ___ ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ______
(b) General nature of industry, business, or establishment in which employed (or employer): Coal Miner

BIRTHPLACE (City or town, State or foreign country): Mo.

PARENTS
NAME OF FATHER: Dan Stevenson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Dont Know
MAIDEN NAME OF MOTHER: Vina Stone
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Virgnia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E L Stevenson
(ADDRESS) Camden, Mo.

Filed 8-30-18 191__ W. W. Burgess REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug (Month) 30 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 16, 1918, to Aug 30, 1918, that I last saw him alive on Aug 29, 1918, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
Cirrhosis of Liver
124B
92A

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY): Chronic Endocarditis

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) G. S. Pennington M. D.
8/30 1918 (Address) Camden Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death? ______
Former or usual residence ______

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Camden, Cem.	8-31-18 1918

UNDERTAKER: W. W. Burgess. ADDRESS: Camden, Mo.
W. W. Burgess

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County ____________

Township ____________ Registration District No. ____________ File No. ____________

or

Village ____________ Primary Registration District No. ____________ Registered No. ____________

or

City ____________ (NO. ________, ____________ St.; ________ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME ____________

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)	DATE OF DEATH ____________ (Month) ______ (Day), 191____ (Year)
DATE OF BIRTH ____________ (Month) ______ (Day), 1____ (Year)			I HEREBY CERTIFY, that I attended deceased from ____________, 191____, to ____________, 191____,
AGE ________ yrs. ________ mos. ________ ds.		If LESS than 1 day, ____ hrs. or ____ min.?	that I last saw h____ alive on ____________, 191____, and that death occurred, on the date stated above, at ________ m.
OCCUPATION (a) Trade, profession, or particular kind of work ____________			The CAUSE OF DEATH* was as follows: ____________
(b) General nature of industry, business, or establishment in which employed (or employer) ____________			____________
BIRTHPLACE (City or town, State or foreign country)			____________ (Duration) ________ yrs. ________ mos. ________ ds.
PARENTS: NAME OF FATHER			Contributory ____________ (SECONDARY) ____________ (Duration) ________ yrs. ________ mos. ________ ds.
PARENTS: BIRTHPLACE OF FATHER (City or town, State or foreign country)			(Signed) ____________ M. D.
PARENTS: MAIDEN NAME OF MOTHER			____________, 191____ (Address) ____________
PARENTS: BIRTHPLACE OF MOTHER (City or town, State or foreign country)			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
(Informant) ____________			Where was disease contracted if not at place of death? ____________
(ADDRESS) ____________			Former or usual residence ____________
			PLACE OF BURIAL OR REMOVAL ____________ / DATE OF BURIAL ____________, 191____
Filed ____________, 191____, ____________ REGISTRAR			UNDERTAKER ____________ / ADDRESS ____________