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

Do not use this space.

41805

1. PLACE OF DEATH
County Ray Co Registration District No. 7453
Township Excelsior Springs Primary Registration District No. 4445
City Excelsior Springs (No. ..... St. ..... Ward)

File No. .....
Registered No. 32

2. FULL NAME James Dudley Stevenson

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~
HUSBAND OF (OR) ~~WIFE OF~~ Lucy Jane Stevenson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3/24/1862

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	67	9	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Jackson Co
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER John Stevenson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Mary Ann Stone
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

14. INFORMANT Cecil Stevenson
(Address) Orrick Mo

15. FILED Dec 5 1929 L. E. Ellis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-3 1929

17. I HEREBY CERTIFY, That I attended deceased from 11-28 1929 to 12-3 1929
that I last saw h... alive on Dec 3 1929 and that death occurred, on the date stated above, at 12-05 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia (ut)
(duration) ..... yrs. ..... mos. 6 ds.
CONTRIBUTORY (SECONDARY) same
(duration) ..... yrs. ..... mos. 6 ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH same
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? examination
(Signed) C. R. Williams, M. D.
, 19 (Address) Orrick, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
New Hope Cemet	12-4 1929
20. UNDERTAKER C. W. Gibson	ADDRESS Orrick Mo

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