

M. 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.

WRITE PLAINLY, WITH UNFADING INK, IN THIS SPACE FOR PHYSICIAN'S SIGNATURE AND RECORD.

1 PLACE OF DEATH		STATE OF MICHIGAN	
County <u>Eaton</u>		Department of State—Division of Vital Statistics	
Township _____		TRANSCRIPT OF CERTIFICATE OF DEATH	
Village <u>Vermontville</u>		Registered No. <u>22</u>	
City _____		(No. _____ St. _____ Ward _____)	
(if death occurred in a hospital or institution, give its NAME instead of street and number.)			
2 FULL NAME <u>Allen E. Stone</u>			
(a) Residence. No. _____		St., Ward. _____	
(Usual place of abode.)		(If non-resident 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 <u>Female</u>	4 Color or Race <u>white</u>	5 Single, Married, Widowed or Divorced (write the word.) <u>Married</u>	
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of <u>12-16-1843</u>			
6 DATE OF BIRTH (Month, day and year.)			
7 AGE	Years	Months	Days
	<u>87</u>		<u>15</u>
If LESS than 1 day, _____ hrs. OR _____ min.			
8 OCCUPATION OF DECEASED			
(a) Trade, profession, or particular kind of work <u>Housewife</u>			
(b) General nature of industry, business, or establishment in which employed (or employer)			
(c) Name of employer			
9 BIRTHPLACE (city or town) (State or country) <u>New York</u>			
10 NAME OF FATHER <u>William Dale</u>			
11 BIRTHPLACE OF FATHER (city or town) (State or country) <u>New York</u>			
12 MAIDEN NAME OF MOTHER <u>Margaret Miller</u>			
13 BIRTHPLACE OF MOTHER (city or town) (state or country) <u>Germany</u>			
14 Informant <u>Mrs. Alf Faust</u> (Address) <u>Vermontville Mich</u>			
15 Filed <u>Jan 3, 1931</u> <u>Oliver Hine</u> Registrar.			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH (Month, day and year) <u>12-31</u> 19 <u>30</u>			
17 I HEREBY CERTIFY, That I attended deceased from <u>Dec 20</u> , 19 <u>30</u> , to <u>Dec 31</u> , 19 <u>30</u> that I last saw her alive on <u>Dec 31</u> , 19 <u>30</u> and that death occurred on the date stated above at <u>7:30</u> p.m. The CAUSE OF DEATH* was as follows: <u>Angina Pectoris</u>			
(duration) _____ yrs. <u>10</u> mos. _____ ds.			
CONTRIBUTORY <u>General Heart</u> (Secondary)			
(duration) _____ yrs. _____ mos. _____ ds.			
18 Where was disease contracted If not at place of death? _____			
Did an operation precede death? <u>no</u> Date of _____			
Was there an autopsy? <u>no</u>			
What test confirmed diagnosis? <u>Heart</u>			
(Signed) <u>C. S. Hull</u> , M. D. _____, 19 _____, Address _____			
*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. (See reverse side for further instructions.)			
19 PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Wood Lawn Cem</u> Date of Burial <u>Jan 3</u> 19 <u>31</u>			
2 UNDERTAKER <u>C. L. West Nashville</u> Address _____			