

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7145

State File No.

| | | | | | | | |
|--|-------------------------------|---|---|---|---|--|-----------------------------|
| BIRTH NO. | | REG. DIST. NO. <u>347</u> | | PRIMARY REG. DIST. NO. <u>6155</u> | | Registrar's No. <u>5</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>Stone</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before adjustment) a. STATE <u>MO</u> b. COUNTY <u>Stone</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Alpine-township</u> | | c. LENGTH OF STAY (In this place) <u>Life</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u> | | | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION | | | | d. STREET ADDRESS (If rural, give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | a. (First) <u>John</u> | b. (Middle) <u>H.</u> | c. (Last) <u>Stalions</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>1 5 1949</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>June 21-1874</u> | 9. AGE (In years last birthday) <u>74</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Rube Stalions</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Sarah TAYLOR</u> | | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mary Martin Shell Knob, Mo.</u> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Mitral Insufficiency</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arthritis</u> DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>3 yrs</u> | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Bronchitis</u> | | | | 17. <u>1 yr</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>124X</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Nov 10, 1948</u> , to <u>Jan 5, 1949</u> , that I last saw the deceased alive on <u>Nov 10, 1948</u> , and that death occurred at <u>1020 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>L.S. Shumate, M.D.</u> | | | | 23b. ADDRESS <u>Reeds Spring, Mo.</u> | | 23c. DATE SIGNED <u>1/6/49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>1-6-49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Owens Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>Stone County Mo.</u> | |
| DATE REC'D BY LOCAL REG. <u>Feb 4 1949</u> | | REGISTRAR'S SIGNATURE <u>Mo J. Schmer</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>No. Funeral Director</u> | | ADDRESS | |

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 349-205

Date Filed 3-3-49

Mrs J E BRASSER
Valencia
Ind

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

No Embalming done.

Licensed Embalmer No.....

P. O. Address.....

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

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