

FILED APR 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9001

BIRTH NO. _____		REG. DIST. NO. 171		PRIMARY REG. DIST. NO. 4267		Registrar's No. 5	
1. PLACE OF DEATH a. COUNTY Lafayette				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lafayette 54			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Odessa 1		c. LENGTH OF STAY (In this place) 34 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Odessa 4			
d. FULL NAME OF HOSPITAL OR INSTITUTION South 2nd St. Odessa				d. STREET ADDRESS (If rural, give location) South 2nd St. 0			
3. NAME OF DECEASED (Type or Print) a. (First) William Stone			b. (Middle) Felts			4. DATE OF DEATH (Month) (Day) (Year) Apr. 4, 1949	
5. SEX Male 0		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1		8. DATE OF BIRTH Mar. 5, 1871	
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kentucky 1	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Isaac Felts		13b. MOTHER'S MAIDEN NAME Elizabeth Stone		14. NAME OF HUSBAND OR WIFE Ethel Felts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Ethel Felts Odessa, Mo.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Arteriosclerosis ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis general DUE TO (c) Coronary Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Dementia.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION No operation				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No injury		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Odessa Lafayette Mo			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		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 1844, 1844, 1849, that I last saw the deceased alive on April 4, 1949, and that death occurred at 10:30 a.m. from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) W.E. Martin 0				23b. ADDRESS Odessa, Mo.		23c. DATE SIGNED 4/6/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr. 7, 1949		24c. NAME OF CEMETERY OR CREMATORY Odessa Cemetery		24d. LOCATION (City, town, or county) (State) Odessa, Mo.	
DATE REC'D BY LOCAL REG. Apr. 6 '49		REGISTRAR'S SIGNATURE Letta D. Drummond 153		25. FUNERAL DIRECTOR'S SIGNATURE Husman-Sparks		ADDRESS Odessa, Mo.	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

District File Number

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Date Filed 4-12-69

SEP 4 1963

**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.

Signed: \_\_\_\_\_  
Student Embalmer

Signed

*William T. Sparks*

Licensed Embalmer No. <sup>#</sup> 4431

P. O. Address Odessa, Mo.

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

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