No. 300
No. 48

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

FILED MAY 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16536

BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3046 Registrar's No. 53

1. PLACE OF DEATH
a. COUNTY Livingston
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chillicothe
c. LENGTH OF STAY (In this place) 10 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Chillicothe Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Mo
b. COUNTY Livingston
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 415 Herriman
d. STREET ADDRESS (If rural, give location) Chillicothe Mo.

3. NAME OF DECEASED (Type or Print)
a. (First) Mary
b. (Middle) T
c. (Last) Stephens

4. DATE OF DEATH (Month) May (Day) 9 (Year) 49

5. SEX F

6. COLOR OR RACE Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Sept 6 - 1898

9. AGE (In years last birthday) 50

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Linneus Mo

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Dayfett Brown

13b. MOTHER'S MAIDEN NAME Katy Williams

14. NAME OF HUSBAND OR WIFE William O. Stephens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME W. O. Stephens
ADDRESS Chillicothe 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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 3 yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

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19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION None

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) No

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) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10, 1947, *to* May 9, 1949, *that I last saw the deceased alive on* May 9, 1949, *and that death occurred at* 7 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Joseph A. Conrad (Degree or title) M.D.

23b. ADDRESS Chillicothe, Mo

23c. DATE SIGNED May 10-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE May 10-49

24c. NAME OF CEMETERY OR CREMATORY Meadville

24d. LOCATION (City, town, or county) Meadville (State) Mo

DATE REC'D BY LOCAL REG. May 10 1949

REGISTRAR'S SIGNATURE Frances B Neill

25. FUNERAL DIRECTOR'S SIGNATURE C. Beckett
ADDRESS Chillicothe Mo.

(Licensed Embalmer's Statement on Reverse Side)

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY (If within corporate limits, write WITHIN) and give township) OR TOWN
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE
b. COUNTY
c. CITY (If within corporate limits, write WITHIN) and give township) OR TOWN
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or print) a. (First) b. (Middle) c. (Last)
4. DATE OF DEATH (Month) (Day) (Year)
5. SEX
6. COLOR OR RACE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH
9. AGE (In years) Last birthday) Years
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known) If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME
ADDRESS

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18. CAUSE OF DEATH
Enter only one cause on line for (a), (b), and (c)
*This does not mean the mode of dying, such as heart failure, asthenia, etc.
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____
AN ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause, stating the underlying cause last. (b) _____ DUE TO (a)
(c) _____ DUE TO (b)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. _____ DUE TO (c)
19. If woman, the disease, injury or complication that caused death.
20. DATE OF OPERATION
21. MAJOR FINDINGS OF OPERATION
22. AUTOPSY? YES ☐ NO ☐
INTERVAL BETWEEN ONSET AND DEATH

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 _____ working under my personal supervision.

Student Embalmer No. _____

23a. ACCIDENT SUICIDE HOMICIDE
(Specify)
23b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, school, etc.)
23c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)
23d. TIME OF INJURY
23e. HOW DID INJURY OCCUR?
23f. INJURY RECEIVED WHILE AT WORK? YES ☐ NO ☐

Signed _____ Student Embalmer

Signed _____ Licensed Embalmer No. 3227

Subscribed and sworn to before me this _____ day of _____, 19____, from the express data on the date stated above.

_____ M., and that death occurred at _____ P. O. Address _____

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY
24d. ADDRESS (Degree or title)
24e. DATE SIGNED

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.

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF PUBLIC HEALTH AND WELFARE
DIVISION OF HEALTH
VITAL STATISTICS