

FILED JUL 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22946

3000
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____ REG. DIST. NO. 76 PRIMARY REG. DIST. NO. 5381 Registrar's No. 60

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Dallas</u>	
b. CITY OR TOWN <u>Junco</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Junco</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED a. (First) <u>NEVA</u> b. (Middle) <u>E.</u> c. (Last) <u>Stidham</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7-8-49</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>12-18-1906</u>
9. AGE (In years last birthday) <u>42</u>		10. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>Bert Reitchmeyer</u>		13b. MOTHER'S MAIDEN NAME	
14. NAME OF HUSBAND OR WIFE <u>Robert Stidham</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Robert Stidham, Junco</u> ADDRESS	
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) <u>Carcinoma of Uterus</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
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>April 1, 1949</u> , to <u>July 8, 1949</u> , that I last saw the deceased alive on <u>7-8, 1949</u> and that death occurred at <u>5:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>D. O. Shannon</u> (Degree or title)		23b. ADDRESS <u>Buffalo Mo</u>	
23c. DATE SIGNED <u>7-11-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-10-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hope Well</u>	24d. LOCATION (City, town, or county), (State) <u>Dallasco. Mo.</u>
DATE REC'D BY LOCAL REG. <u>7/23/49</u>	REGISTRAR'S SIGNATURE <u>Mr. J. B. Jones</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. D. Jones</u> ADDRESS <u>Buffalo, Mo.</u>	

AUG 4 1945

AUG 8 1946

RECEIVED

District Health Officer No: 7

District File Number 6-49-82

Date Filed 7-25-46

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 James B. Jones

Signed _____
Student Embalmer

Licensed Embalmer No. 4322

P. O. Address Buffalo, 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.