

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 15 1950

State File No.

BIRTH NO.		REG. DIST. NO. <u>71</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>7</u>		
1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>				
b. CITY (If outside corporate limits, write RURAL and give town) <u>Excelsior Springs</u>		c. LENGTH OF STAY (In this place) <u>2 yrs. 5 mos.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Lexington</u>		8540		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>VA Hospital, Excelsior Springs, Mo.</u>				d. STREET ADDRESS (If rural, give location) <u>Route 1</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fred</u> b. (Middle) <u>Stevens</u> c. (Last) <u>Stevens</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 18, 1950</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 20, 1900</u>		
9. AGE (In years last birthday) <u>49</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Harrisonville, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Stevens</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Ellen Randolph</u>			14. NAME OF HUSBAND OR WIFE <u>Daisy M. Stevens</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>496031614</u>		17. INFORMANT'S SIGNATURE OR NAME <u>VA Hospital Records</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral encephalopathy, cause undetermined</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>--</u> DUE TO (c) <u>--</u> II. OTHER SIGNIFICANT CONDITIONS <u>Tuberculosis, pulmonary, chronic, far advanced, active, severe</u> Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION <u>--</u>		19b. MAJOR FINDINGS OF OPERATION <u>--</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>--</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>--</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>--</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>VA</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>--</u>				
22. I hereby certify that I attended the deceased from <u>July 29, 1947</u> , to <u>Jan. 18, 1950</u> , that I attended the deceased <u>and that death occurred at 8:25 Pm., from the causes and on the date stated above.</u>								
23a. SIGNATURE <u>A. A. SPRONG</u> (Degree or title) <u>M. D.</u>				23b. ADDRESS <u>Excelsior Springs, Mo.</u>		23c. DATE SIGNED <u>1/19/50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		24b. DATE <u>1-18-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>--</u>		24d. LOCATION (City, town, or county) (State) <u>--</u>		
DATE REC'D BY LOCAL REG. <u>1/18/50</u>		REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Porter</u> ADDRESS <u>Richmond Mo</u>				

RECEIVED FEB 3
District Health Officer No. 8
District File Number _____
Date Filed 2-14-50

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. _____

Student _____
Student Embalmer

Signed Thomas J. Carter

Licensed Embalmer No. 4474

P. O. Address Richmond 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.