

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 26 1950

State File No. 982

S. No. 300  
v. 10.48

0458  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3024 Registrar's No. 3

1. PLACE OF DEATH a. COUNTY <u>SAXXEX Howard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Slater, Mo.</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fayette</u> OR TOWN		c. LENGTH OF STAY (In this place) <u>13 days</u>	
c. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u> OR TOWN		d. STREET ADDRESS (If rural, give location) <u>1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lee Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Benjamin</u> b. (Middle) <u>Lee</u> c. (Last) <u>Stipes</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 16 '50</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>Aug. 27, 1866</u>
9. AGE (In years last birthday) <u>83</u>		10. MONTHS <u>5</u>	11. DAYS <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Daniel Daniel Stipes</u>	
13b. MOTHER'S MAIDEN NAME <u>Miss Dawes</u>		14. NAME OF HUSBAND OR WIFE <u>widowed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Robt. Beadles, Slater-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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Rght hemiplegia</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"/>		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) (m.) _____		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>Jan 4</u> , 19 <u>50</u> , to <u>Jan 16</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Jan 14</u> , 19 <u>50</u> , and that death occurred at <u>12:30P</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Francis W. Dean M.D.</u> (Degree or title)		23b. ADDRESS <u>Lee Hospital Fayette, Mo</u>	
23c. DATE SIGNED <u>1-17-50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	
24b. DATE <u>1/18/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Slater City</u>	
24d. LOCATION (City, town, or county) (State) <u>Slater, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Will Brothers, Slater, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1-17-50</u>		REGISTRAR'S SIGNATURE <u>Mary K. Shell</u> <u>436</u>	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED JAN 25  
District Health Officer No. 8,  
District File Number \_\_\_\_\_  
Date Filed 1-25-50

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed A. C. Hill

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

Licensed Embalmer No. 3090

P. O. Address Slater, 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.