

FILED APR 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10052**

BIRTH NO. _____ REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 6062 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Collins b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL, and give OR TOWN Collins (Rural))		c. CITY (If outside corporate limits, write RURAL, and give township) Collins (Rural)	
c. LENGTH OF OR TOWN 77 years		d. STREET ADDRESS (If rural, give location) Doyal trap	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3 mi S.E. Vista Mo.			
3. NAME OF DECEASED a. (First) John		b. (Middle) H.	
c. (Last) Stephens		4. DATE OF DEATH (Month) (Day) (Year) 3/16/50	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/19/1872
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	11. BIRTHPLACE (State or foreign country) St. Clair Co; Mo
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Otha Stephens	
14. MOTHER'S MAIDEN NAME Unknown		15. NAME OF HUSBAND OR WIFE Helen B. Stephens	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. MEDICAL CERTIFICATION	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH ?	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		2. ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____	
DUE TO (c) _____		3. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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>10/23</u> 19 <u>49</u> , to <u>3/16</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>50</u> , and that death occurred at <u>8:25</u> p.m., from the causes and on the date stated above.			
23a. SIGNATURE R. Mark Todd, Jr. M.D. (Degree or title)		23b. ADDRESS Orcutt Mo	
23c. DATE SIGNED 3/17/50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 3/19/50		24c. NAME OF CEMETERY OR CREMATORY Macedonia	
24d. LOCATION (City, town, or county) (State) Vista Mo		DATE REC'D BY LOCAL REG. March 20-50	
REGISTRAR'S SIGNATURE Ruth Seavers		25. FUNERAL DIRECTOR'S SIGNATURE J.B. Goodrich	
ADDRESS 288		ADDRESS Orcutt Mo	

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

RECEIVED
District Health Officer No. 7,
District File Number 3-50-351
Date Filed 4-10-50

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.

Student _____
Student Embalmer

Signed J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Asheville, N.C.

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.