

FILED APR 21 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13879

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 221 PRIMARY REG. DIST. NO. 5804 Registrar's No. 19

0690

1. PLACE OF DEATH a. COUNTY <u>MONROE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL-JACKSON</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL-JACKSON</u> 0690	
c. LENGTH OF STAY (In this place) <u>3 YEARS</u>		d. STREET ADDRESS (If rural, give location) <u>1 MI. S.W. OF PARIS, MO.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1 MI. S.W. OF PARIS MO</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>R.</u> c. (Last) <u>STEPHENS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>APR 10, 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>JAN. 16, 1887</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL FARMING</u>	11. BIRTHPLACE (State or foreign country) <u>MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>W. W. STEPHENS</u>	13b. MOTHER'S MAIDEN NAME <u>KATE CRAIG</u>	14. NAME OF HUSBAND OR WIFE <u>LUCILLE F. STEPHENS</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WORLD WAR I</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Lucille F. Stephens</u>	ADDRESS _____
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>592X</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral apoplexy</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary insufficiency</u> DUE TO (c) <u>chronic nephritis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>apoplexy - RT side - four years ago</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from Nov, 1940, to APR 10, 1950, that I last saw the deceased alive on 4-10, 1950, and that death occurred at 11:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Nellis S. Christman D.O.</u> (Degree or title)	23b. ADDRESS <u>PARIS, MO.</u>	23c. DATE SIGNED <u>4-11-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>4-12-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE</u>	24d. LOCATION (City, town, or county) (State) <u>PARIS, MO.</u>
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DATE REC'D BY LOCAL REG. <u>APR. 11, 1950</u>	REGISTRAR'S SIGNATURE <u>F. A. Barnard M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Speed &amp; Blakey Paris, Mo.</u>	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

APR 21 1950

RECEIVED

APR 17 1950

District Health Officer No.

District File Number H-20-6

Date Filed APR 17 1950

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 E. P. Wagner

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

Licensed Embalmer No. 4000

P. O. Address Paris, Missouri

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.