

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36680**

FILED NOV 25 1950

|  |  |   |            |   |           |   |  |
|--|--|---|------------|---|-----------|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <b>128</b>   |            | PRIMARY REG. DIST. NO. <b>2000</b>  |           | Registrar's No. <b>1037</b>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>GREENE</b>   |  |   |            | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b> |           |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>SPRINGFIELD</b>   |  | c. LENGTH OF STAY (in this place)   |            | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>SPRINGFIELD</b> <b>0396</b>                            |           |   |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location)<br>HOSPITAL OR INSTITUTION <b>909 S. DOLLISON</b>   |  |   |            | d. STREET ADDRESS (If rural, give location)<br><b>308 1/2 W. COMMERCIAL</b>   |           |   |  |
| 3. NAME OF DECEASED<br>(Type or Print) <b>STEPHEN</b>  |  |   | a. (First) | b. (Middle)   | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Nov. 21 1950</b>                        |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>   |            | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>DIVORCED 3</b>   |           | 8. DATE OF BIRTH<br><b>30 AUGUST 1867</b>   |  |
| 9. AGE (In years last birthday) <b>83</b>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>                         |            | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>   |           | 11. BIRTHPLACE (State or foreign country)<br><b>NEBRASKA</b> <b>1</b>               |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13a. FATHER'S NAME<br><b>I. N. COOPER</b>   |            | 13b. MOTHER'S MAIDEN NAME<br><b>MARTHA J. SLAGLE</b>  |           | 14. NAME OF HUSBAND OR WIFE<br><b>✓</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>No</b>   |            | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>CLYDE C. COOPER</b> <b>SPRNGD. MO.</b>  |           |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arterio-Sclerotic Heart Disease</b>                                       |            |   |           | 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.   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |            |   |           | <b>4-0-0</b>  |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION  |            |   |           | 20. AUTOPSY?<br>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) (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 <b>July</b> , 19 <b>50</b> , to <b>Nov 21</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>Nov 20</b> , 19 <b>50</b> and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above. |  |   |            |   |           |   |  |
| 23a. SIGNATURE <b>Max Felt</b> (Deceased or UG)  |  |   |            | 23b. ADDRESS <b>Springfield Mo</b>  |           | 23c. DATE SIGNED <b>11-24-50</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 24b. DATE <b>11-25-50</b>   |            | 24c. NAME OF CEMETERY OR CREMATORY<br><b>GREENLAWN CEME.</b>  |           | 24d. LOCATION (City, town, or county) (State)<br><b>SPRINGFIELD MO.</b>             |  |
| DATE REC'D BY LOCAL REG.<br><b>11-25-50</b>  |  | REGISTRAR'S SIGNATURE<br><b>W. E. Handley</b>   |            | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>J. W. Klingner &amp; Co. Spgfd. Mo.</b>  |           |   |  |

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

396

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**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.....

*J. B. Langner*

Signed.....

Student Embalmer

Licensed Embalmer No. 3358

P. O. Address.....

**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.