

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB. 16 1951
0143

State File No. 4001

BIRTH NO. 2 REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 308 Registrar's No. 28

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Callaway</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo</i> b. COUNTY <i>Boone</i> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Fulton</i> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Columbia</i> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <i>State Hospital Mo</i> | | d. STREET ADDRESS (If rural, give location) <i>209 Price Ave</i> | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) <i>FLORENCE</i> b. (Middle) <i>STEWART</i> c. (Last) <i>KEENE</i> | | | 4. DATE OF DEATH (Month) (Day) (Year) <i>Jan 29 1951</i> | | |
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| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>widow</i> | 8. DATE OF BIRTH <i>June 15 1872</i> | 9. AGE (In years last birthday) <i>79</i> | IF UNDER 1 YEAR Months <i>7</i> Days <i>14</i> | IF UNDER 24 HRS. Hours <i></i> Mins. <i></i> |
|-----------------|-------------------------------|---|--------------------------------------|---|---|---|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife clerk Retail Store</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>Retail Store</i> | 11. BIRTHPLACE (State or foreign country) <i>Boone Co Mo</i> | 12. CITIZEN OF WHAT COUNTRY? <i>America</i> |
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| 13a. FATHER'S NAME <i>J H Stewart</i> | 13b. MOTHER'S MAIDEN NAME <i>Mildred Phelps</i> | 14. NAME OF HUSBAND OR WIFE <i>deceased</i> |
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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) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME | 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, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <i>45ix</i> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Ruptured Aortic aneurism</i> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>hemorrhage with cardiac tamponade</i> DUE TO (c) <i>aortic arterio sclerosis</i> Conditions contributing to the death but not related to the disease or condition causing death. <i>chronic nephritis</i> | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (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 *Jan 29 1951*, to *Jan 29 1951*, that I last saw the deceased alive on *Jan 28 1951*, and that death occurred at *7:00 a.m.* from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <i>R. P. Price D Md</i> | 23b. ADDRESS <i>State Hospital Fulton Mo</i> | 23c. DATE SIGNED <i>1-29-51</i> |
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|---|------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 24b. DATE <i>Jan 31 1951</i> | 24c. NAME OF CEMETERY OR CREMATORY <i>New Salem</i> | 24d. LOCATION (City, town, or county) (State) <i>Boone Co. Mo</i> |
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| DATE REC'D BY LOCAL REG. <i>Feb. 10 1951</i> | REGISTRAR'S SIGNATURE <i>Maretha Lawrence</i> | 436 | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Wesley Funeral Service</i> | ADDRESS <i>Columbia, Mo</i> |
|--|---|-----|--|-----------------------------|

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

File No. _____
DISTRICT HEALTH OFFICE No. 4

FEB 13 1951

RECEIVED

1951 FEB 17 031

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.

Signed.....
Student Embalmer

Signed

Student Embalmer No.
Clarence M. Billo

Licensed Embalmer No. *4375*

P. O. Address *Columbia, 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.