

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43829**

JAN 9 1952

BIRTH NO. _____ REG. DIST. NO. **360** PRIMARY REG. DIST. NO. **3076** Registrar's No. **209**

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Vernon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Nevada	c. LENGTH OF STAY (In this place) 9 das.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Nevada 1960s	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mc Cart Nursing Home		d. STREET ADDRESS (If rural, give location) 817 N. Commercial	

3. NAME OF DECEASED (Type or Print)	a. (First) Charles	b. (Middle)	c. (Last) Stevens	4. DATE OF DEATH (Month) (Day) (Year) Dec. 30 1951
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Nov. 1, 1870	9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) Hartwell, Missouri	12. CITIZENRY OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME William Stevens	13b. MOTHER'S MAIDEN NAME Melissa Wright	14. NAME OF HUSBAND OR WIFE Lillie May Stevens
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Lillie May Stevens ADDRESS Nevada Mo.
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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 7 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis years 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 331X	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 **July 6, 1951**, to **Dec 30, 1951**, that I last saw the deceased alive on **July 6, 1951**, and that death occurred at **3:45** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ray W. Pearson, M.D.	23b. ADDRESS Nevada Mo.	23c. DATE SIGNED 12/31/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 1, 1952	24c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	24d. LOCATION (City, town, or county) (State) Schell City Mo.
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DATE REC'D BY LOCAL REG. Jan 1/51	REGISTRAR'S SIGNATURE Anna E. Ferry 451	25. FUNERAL DIRECTOR'S SIGNATURE Lewis & Son ADDRESS Schell City, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Student
Student Embalmer

Signed Marion M. Lewis

Licensed Embalmer No. 3084

P. O. Address Schell City, 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.