.S. No. 300
v. 10-40

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

127

State File No. _____

FILED JAN 12 1953

BIRTH NO. 199 REG. DIST. NO. 11 PRIMARY REG. DIST. NO. 5052 Registrar's No. 1

0050
1

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

1. PLACE OF DEATH
a. COUNTY: Barry
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Roaring River
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Junction Highway F & P Eagle Rock

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Barry
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural 0050
d. STREET ADDRESS (If rural, give location): 5 miles East Roaring River Park

3. NAME OF DECEASED (Type or Print)
a. (First): Michael
b. (Middle): Dean
c. (Last): Steverson

4. DATE OF DEATH (Month) (Day) (Year): Jan 6, 1953

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): ~~[illegible]~~ 0
8. DATE OF BIRTH: Jan 6, 1953
9. AGE (In years last birthday): If under 1 year: Months / Days; If under 24 hrs.: Hours 1 Min. 00

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Premature
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and State or Foreign Country): Barry Co. Mo. 0
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Leonard G. Steverson
13b. MOTHER'S MAIDEN NAME: Barbara L. Bradford
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs Earl Bradford

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Premature — INTERVAL BETWEEN ONSET AND DEATH: 22 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): _____
DUE TO (c): 776 X

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
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 6, 1953, *to* Jan 6, 1953, *that I last saw the deceased alive on* Jan 6, 1953, *and that death occurred at* 11:00 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thomas I. Durm, M.D.
23b. ADDRESS: Cassville, Mo.
23c. DATE SIGNED: Jan 8, 1953

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: Jan 8-53
REGISTRAR'S SIGNATURE: Grace Williams 10-0
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: No Funeral director

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

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.