

FILED AUG 23 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26877

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>300</u>		Registrar's No. <u>792</u>											
1. PLACE OF DEATH a. COUNTY <u>Green</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u>				b. COUNTY <u>Christian</u>									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>				c. LENGTH OF STAY (in this place) <u>7 Das.</u>		c. CITY OR TOWN <u>Rogersville, Mo.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Springfield Baptist Hos.</u>				e. STREET ADDRESS (If rural, give location) <u>Rural, Linden Twp.</u>				02201									
3. NAME OF DECEASED (Type or Print)			a. (First)			b. (Middle)			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year)					
<u>Benjamin</u>			<u>Allen</u>			<u>Stone</u>			<u>Aug. 17, 1954</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>Oct. 10, 1878</u>		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
						<u>75</u>		Months		Days		Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>				11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Bob Stone</u>				13b. MOTHER'S MAIDEN NAME <u>Caldonia Walker</u>				14. NAME OF HUSBAND OR WIFE <u>Mrs. Alice C. Stone</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>				17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Alice Stone, Rogersville, Mo.</u>				ADDRESS <u>RF</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH					
				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral damage due to accident</u>													
				ANTECEDENT CAUSES													
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				DUE TO (b) _____													
				DUE TO (c) _____													
				II. OTHER SIGNIFICANT CONDITIONS													
				Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture - Dislocation Rt. Hip</u>													
19a. DATE OF OPERATION <u>8-10-54</u>				19b. MAJOR FINDINGS OF OPERATION <u>Respiratory obstruction</u>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>				21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>road</u>				21c. (CITY, TOWN OR TOWNSHIP) (COUNTY) (STATE) <u>Finley Twp, Christian Co. MO</u>									
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug. 10, 1954</u>				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21f. HOW DID INJURY OCCUR? <u>2 car accident 022</u>									
22. I hereby certify that I attended the deceased from <u>8-10</u> , 19 <u>54</u> , to <u>8-17</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>8-16</u> , 19 <u>54</u> , and that death occurred at <u>12 P.M.</u> , from the causes and on the date stated above.																	
23a. SIGNATURE <u>Jerry N. Allen, M.D.</u>						23b. ADDRESS <u>500 Halland St., Springfield, Mo.</u>						23c. DATE SIGNED <u>18 Aug 54</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				24b. DATE <u>Aug. 19, 54</u>				24c. NAME OF CEMETERY OR CREMATORY <u>Linden Cemetery</u>				24d. LOCATION (City, town, or county) (State) <u>Christian, Missouri</u>					
DATE REC'D BY LOCAL REG. <u>8-18-54</u>				REGISTRAR'S SIGNATURE <u>Smith Williamson</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Chaffin</u>				ADDRESS <u>Ozark, Mo.</u>					

(Licensed Embalmers' Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed *T. B. Chaffin*.....

Licensed Embalmer No. *219*.....

P. O. Address *Ozark*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.