

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32883**

FILED OCT 24 1955

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>918</u>			
1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (in this place) 5 Days		c. CITY OR TOWN Springfield		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital				e. STREET ADDRESS (If rural, give location) RFD#10 Box 314 0341					
3. NAME OF DECEASED (Type or Print) a. (First) JOHN		b. (Middle) ALLEN		c. (Last) STEVER		4. DATE OF DEATH (Month) (Day) (Year) October 19, 1955			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 1914 31 July 1900			
9. AGE (In years last birthday) 41		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resturant Operator		10b. KIND OF BUSINESS OR INDUSTRY Resturant		11. BIRTHPLACE (City and State or Foreign Country) Greene County, Mo.		12. CITIZEN OF WHAT COUNTRY? usa			
13a. FATHER'S NAME John R. Stever			13b. MOTHER'S MAIDEN NAME Betty Thompson			14. NAME OF HUSBAND/OR WIFE Dolores Stever			
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. 491-03-6981		17. INFORMANT'S SIGNATURE OR NAME Dolores Stever ADDRESS Springfield, Mo.					
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignant Lymphoma (Lymphoblastic)				INTERVAL BETWEEN ONSET AND DEATH 6 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) _____					
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 2002					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 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 <u>9-13</u> , 19 <u>55</u> , to <u>10-19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-19</u> , 19 <u>55</u> , and that death occurred at <u>3:10P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <i>E. Simpson</i>				23b. ADDRESS 1630 N. Jefferson Springfield, Missouri		23c. DATE SIGNED 10-19-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-21-55		24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		24d. LOCATION (City, town, or county) (State) Springfield, Missouri			
DATE REC'D BY LOCAL REG. 10-21-55		REGISTRAR'S SIGNATURE <i>Edith Williams</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. Klingner</i> ADDRESS 6. Springfield, Mo.					

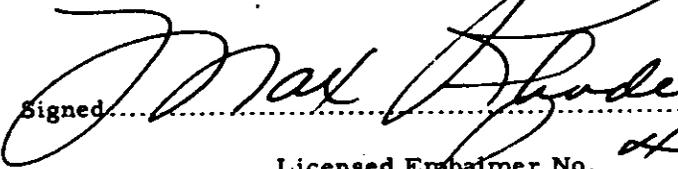
(Licensed Embalmer Statement on Reverse Side) *JAC*

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..... 

Licensed Embalmer No. *44*

P. O. Address..... 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.