

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4084

STATE FILE NUMBER

FILED FEB 27 1957

Registration District No. 75 Primary Registration District No. 3815 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>		
b. CITY (If outside corporate limits, give-TOWNSHIP only) OR TOWN <u>Cameron</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY - OR TOWN <u>Altamont</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cameron Community Hosp.</u>		Length of stay in lb <u>10 Days</u>	d. STREET ADDRESS <u>---</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lowell</u> Middle <u>Willis</u> Last <u>Stephens</u>			4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12 1884</u>	9. AGE (In years last birthday) <u>72</u>	
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 Owner</u>	11. BIRTHPLACE (City and state or country) <u>Clinton Co., Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob R. Stephens</u>			14. MOTHER'S MAIDEN NAME <u>Edna Lancaster</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mrs. Oleva Stephens, Altamont, Mo.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive failure; Uremic state</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio sclerotic heart disease, nephritis, art- erio sclerotic type</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>2</u>		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>Feb 1, 1957</u> to <u>Feb 10, 1957</u> and last saw her/him alive on <u>Feb 10, 1957</u> Death occurred at <u>6 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. D. [Signature]</u> M. D.			22b. ADDRESS <u>Gallatin, Missouri</u>		22c. DATE SIGNED <u>2/15/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/13, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Ayr Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Altamont, Missouri</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u> Address <u>Hope Funeral Home, Gallatin, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-18-57</u>		26. REGISTRAR'S SIGNATURE <u>Francis S Crawford</u>	

(Licensed Embalmer's Statement on Reverse Side)

health, Wellfare Public Service
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 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FEB 27 1957

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.....
L. O. Dickerson

Licensed Embalmer No. *330*

P. O. Address *Pellatim*

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