

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300  
10.48

FILED FEB 21 1957

 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 290 PRIMARY REG. DIST. NO. 5984 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Waynesville, Mo Rt # 2</u> )		c. CITY OR TOWN <u>Waynesville, Mo</u> <sup>0850</sup>	
c. LENGTH OF STAY in this place <u>53 yrs</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>None.</u>		f. STREET ADDRESS (If rural, give location) <u>Rural Rt. # 1.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Arch</u>		b. (Middle) <u>Lee</u>	
c. (Last) <u>Stearns.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 11 1957</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>March 5, 1881</u>
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oil Driller.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Marion Co. State of Virg!</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>M.A. Stearns.</u>	13b. MOTHER'S MAIDEN NAME <u>Delphia Unknown.</u>
14. NAME OF HUSBAND OR WIFE <u>Sarah Pearl Stearns.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>491-24-3186</u>
17. INFORMANT'S SIGNATURE OR NAME <u>Sarah Pearl Stearns</u>		ADDRESS <u>Waynesville, Mo Rural Rt.</u>	
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) <u>Nephritis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prostatitis</u> 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 _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>611X</u>	
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) <u>2</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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>2-10-1957</u> , to <u>2-11-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-10-</u> , 19 <u>57</u> , and that death occurred at <u>12:00</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>E. Miller MD</u>		23b. ADDRESS (Degree or title) <u>MD</u> <u>Waynesville, Missouri</u>	
23c. DATE SIGNED <u>2-13-57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2/14/57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Richland, Missouri</u>
DATE REC'D BY LOCAL REG. <u>2-14-57</u>	REGISTRAR'S SIGNATURE <u>Paula Grace Anderson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hedges</u> ADDRESS <u>Richland Mo</u> <u>Hedges Funeral Home Richland, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 2-16-57  
MUNICIPAL COUNTY HEALTH OFFICE  
File Number 17  
Date Filed 2-14-57

FEB 21 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 *Clarence Moss*

Licensed Embalmer No. *4896*

P. O. Address *Waynesville*

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