

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8204

State File No. ....

FILED APR 8 - 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 0117

1. PLACE OF DEATH a. COUNTY <b>Franklin.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri.</b> b. COUNTY <b>Cole.</b>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>Washington.</b>	c. LENGTH OF STAY (in this place) <b>1 hr.</b>	c. CITY OR TOWN <b>Jefferson City.</b>	d. Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Francis Hospital.</b>		e. STREET ADDRESS (If rural, give location) <b>522 E. High St.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Helen</b>	b. (Middle) <b>Arlene</b>	c. (Last) <b>Stacy.</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Apr. 2nd, 1957.</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 13th, 1932.</b>	9. AGE (In years last birthday) <b>-24-25</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Baptist Gen. Assn.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Chicago, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Harold L. Adams.</b>	13b. MOTHER'S MAIDEN NAME <b>Helen Seifert. Sefkas</b>	14. NAME OF HUSBAND <b>Charles N. Stacy.</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>C. N. Stacy</b>	ADDRESS <b>Jefferson City, Mo.</b>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>Multiple Fractures of skull &amp; cervical</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Acceleration + concussion</b>		
	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? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Wounds</b>	21b. PLACE OF INJURY (Home, farm, factory, street, public place, etc.) <b>11th Ward Mo</b>	21c. (CITY, TOWN, OR TOWNSHIP) <b>Franklin Mo</b>	21d. (COUNTY) <b>Franklin Mo</b>	21e. (STATE) <b>Mo</b>
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21d. TIME OF INJURY <b>April 2 1957 2:00 PM</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Cuts accident</b>
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>[Signature]</b>	(Degree or title)	23b. ADDRESS <b>Union Mo</b>	23c. DATE SIGNED <b>4/2/57</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>April 4, 1957</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>	24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Apr. 2, 1957</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Victor Beecher J.C. Mo.</b>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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.....  
*Lester A. Velt*

Licensed Embalmer No. *375*  
P. O. Address *Washington*

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.

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