

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35298**

FILED NOV 14 1957

BIRTH NO. _____ REG. DIST. NO. 100 PRIMARY REG. DIST. NO. 5388 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY <u>Dent</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> COUNTY <u>Dent</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Short Bend type</u>		c. CITY OR TOWN <u>Salem</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>10 days</u>		e. STREET ADDRESS (If rural, give location) <u>So HW 19 8 miles 030</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>HW 19</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Mary</u>	b. (Middle) <u>M</u>	c. (Last) <u>Stephans</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>11-7-57</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Mar 24 1880</u>	9. AGE (in years last birthday) <u>77</u>	If UNDER 1 YEAR Months _____ Days _____	If UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Dent Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S</u>
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13a. FATHER'S NAME <u>James Hubbs</u>	13b. MOTHER'S MAIDEN NAME. <u>Mary Jane Christian Calvin Stephans</u>	14. NAME OF HUSBAND OR WIFE _____
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Calvin Stephans</u> ADDRESS <u>Salem Mo</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia, hypostatic</u>		<u>3 days</u>
	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. <u>Cerebral hemorrhage</u>		<u>6 months</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>33IX</u>	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from 11/2, 1957, to 11/5, 1957, that I last saw the deceased alive on 11/5, 1957, and that death occurred at 1:45P m., from the causes and on the date stated above.

23a. SIGNATURE <u>Walter M. Hart</u> (Degree or title) _____	23b. ADDRESS <u>Salem, Mo.</u>	23c. DATE SIGNED <u>11/8/57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>11-9-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Dent Co Mo</u>
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DATE REC'D BY LOCAL REG. <u>11/8/57</u>	REGISTRAR'S SIGNATURE <u>M. M. Hart M.D. P.D.M.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter M. Hart</u> ADDRESS <u>Salem Mo</u>
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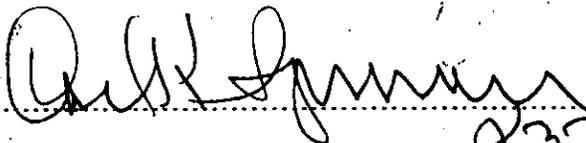
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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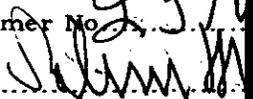
STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 2371

P. O. Address 

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.