

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013257
STATE FILE NUMBER

FILED MAY 12 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 206

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Laclede 0532</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Lebanon</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>UNIVERSITY HOSPITAL</u>			Length of stay in lb <u>9 Days</u>		d. STREET ADDRESS (If outside, give location) <u>625 SPILLER</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>JACOB</u> Last <u>Stevens</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>58</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>Dec. 7, 1890</u>		9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Flour Mill Worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Flour Mill</u>		11. BIRTHPLACE (City and state or country) <u>Table Rock, Neb.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Peter Stevens</u>			13b. MOTHER'S MAIDEN NAME <u>Elvira Steele</u>			14. NAME OF HUSBAND OR WIFE <u>Nellie, Stevens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>			16. SOCIAL SECURITY NO. <u>490-05-8049A</u>		17. INFORMANT <u>Hospital Chart</u>			Address	
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>Shock</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Myocardial Infarction</u>			DUE TO (c) <u> </u>				4201		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Myelium sup. mediastinum</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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> </u>						
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						
20e. PLACE OF INJURY (e.g., in or about home, farm, street, office, shop, etc.) <u> </u>			20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u>		STATE <u> </u>		
21. I attended the deceased from <u>4/23/58</u> to <u>5/2/58</u> and last saw him alive on <u>5/2/58</u> Death occurred <u>5 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22. SIGNATURE <u>Frank A. Mohr, M.D.</u> (Deceased's title)				22b. ADDRESS <u>U. of Mo. Med Center, Columbia, Mo</u>				22c. DATE SIGNED <u>5/2/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6 May 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Englewood cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Clinton Mo</u>			
24. FUNERAL DIRECTOR <u>Sickman Dunning</u>			ADDRESS <u>Clinton Mo</u>		25. DATE RECD. BY LOCAL REG. <u>May 5 1958</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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. 471

P. O. Address Clinton

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.