

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028003

STATE FILE NUMBER

FALL AUG 12 1958

Registration District No. 360

Primary Registration District No. 6225

Registrar's No.

| | | | | | | | |
|---|------------------------------|---|--|---|--|---|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Vernon</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | c. CITY OR TOWN <u>Calhoun</u> | | Outside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT a hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u> | | Length of stay in lb <u>2 mo 6 days</u> | | d. STREET ADDRESS (If outside, give location) <u>Rt 2.</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>OSCAR O. STAIRS</u> | | | | 4. DATE OF DEATH Month Day Year <u>8 6 1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</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>7/30/1889</u> | 9. AGE (In years last birthday) <u>69</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 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>Farming</u> | | 11. BIRTHPLACE (City and state or country) <u>Custer Co. Neb.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>David Stairs</u> | | 13b. MOTHER'S MAIDEN NAME <u>Oliza Southerd</u> | | 14. NAME OF HUSBAND OR WIFE <u>Leona Stairs</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>Hospital records</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>Arteriosclerotic Heart Disease</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>years</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> | | | | | | years | |
| DUE TO (c) _____ | | | | | | 4200 | |
| 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>none</u> | | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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>5/1/58</u> to <u>8/6/58</u> and last saw him alive on <u>8/6/58</u> Death occurred at <u>6 55</u> a m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <u>George Esker M.D.</u> (Degree or title) | | 22b. ADDRESS <u>State Hospital #3</u> | | 22c. DATE SIGNED <u>8/6/58</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>8-6-58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Local</u> | | 23d. LOCATION (City, town, or county) (State) <u>Hebron Neb.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Montgomery Moseley</u> | | ADDRESS <u>Hebron, Neb</u> | | 25. DATE RECD. BY LOCAL REG. <u>8-9-1958</u> | | 26. REGISTRAR'S SIGNATURE <u>Arma E. Herrup</u> | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

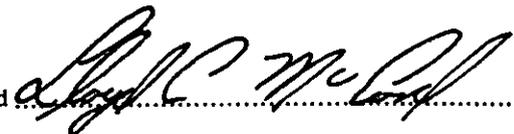
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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. 4853

P. O. Address Florida, Mo.

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.