

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036143

STATE FILE NUMBER

FILED NOV 3 1958

Registration District No. 132 Primary Registration District No. 302 Registrar's No. 164

S. 300
1-57

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Occur, coronary, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

-1. PLACE OF DEATH a. COUNTY <u>Grundy</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Grundy</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Trenton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Excelsior Springs</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>Heal's N. Home</u> Length of stay in lb <u>4 yr's</u>		d. STREET ADDRESS <u>5002</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ursula Jane Stone</u>			4. DATE OF DEATH Month Day Year <u>10 22 1958</u>
5. SEX <u>Fm</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-26-1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Milan Mo</u>
13a. FATHER'S NAME <u>Jefferson Swanger</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Ann Camp</u>	14. NAME OF HUSBAND OR WIFE <u>Marion C. Stone (dead)</u>
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>---</u>	17. INFORMANT Address <u>Erma Mulligan Milan - Mo</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>Chronic Osteo Arthritis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>7230</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs.</u>
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.)	
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>Jan. 9-1954</u> to <u>Oct. 22-1958</u> and last saw ^{her} <u>him</u> alive on <u>9-10-58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>B. H. Buller M.D.</u>		22b. ADDRESS <u>Trenton, Mo.</u>	22c. DATE SIGNED <u>Oct. 24-1958</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-24-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Milan - Mo.</u>
24. FUNERAL DIRECTOR'S ADDRESS <u>Schoene's</u> <u>Maughit Schoene Milan - Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10/24/58</u>	26. REGISTRAR'S SIGNATURE <u>June Jaw</u>

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 *Dwight Schoene*

Licensed Embalmer No. *2667*

P. O. Address *Milan - 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.