Health, Welfare Public Service

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FILED FEB 16 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-004349
STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 51

1. PLACE OF DEATH
a. COUNTY Adair
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Community Nursing Home #1 — Length of stay in 1b 4 months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Putnam
c. CITY OR TOWN Novinger 0860 — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) Rural Route 3 — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First Mary Middle Anna Last Stokes

4. DATE OF DEATH Month Febr. Day 5 Year 1959

5. SEX F
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH 11-23-1874
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Farm Home
11. BIRTHPLACE (City and state or country) Novinger, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME David M. Hatfield
13b. MOTHER'S MAIDEN NAME Cordelia Houghton
14. NAME OF HUSBAND OR WIFE Divorced

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ------
16. SOCIAL SECURITY NO. None
17. INFORMANT Address James D. Stokes, Green Castle, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Circulatory Failure — INTERVAL BETWEEN ONSET AND DEATH: sudden
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Thrombotic Encephalomalacia — weeks
DUE TO (c) Cerebral Arteriosclerosis — unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 8-21-58, to 2-5-59 and last saw her/him alive on 2-5-59
Death occurred at 7:15 P.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George H. Scheurer, D.O.
22b. ADDRESS Kirksville, Mo.
22c. DATE SIGNED 2-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2-8-1959
23c. NAME OF CEMETERY OR CREMATORY Hatfield Cemetery
23d. LOCATION (City, town, or county) (State) Putnam County, Mo.

24. FUNERAL DIRECTOR ADDRESS Glenn E. Kent & Son, Green City, Mo.
25. DATE RECD. BY LOCAL REG. 2-9-1959
26. REGISTRAR'S SIGNATURE Doris W. Ratliff

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
GEORGE H. SCHEURER, D.O.

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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, 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.