

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008228
STATE FILE NUMBER

FILED FEB 16 1959 Registration District No. 373 Primary Registration District No. 4545 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARSHFIELD	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN MARSHFIELD	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location)
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First PHINNIP	Middle	Last STOKES	Month FEB	Day 8
			Year 1959	

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR 6 1879	9. AGE (In years last birthday) 79	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) RET FARMER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
--	-----------------------------------	---	--

13a. FATHER'S NAME RICHARD STOKES	13b. MOTHER'S MAIDEN NAME NETT IKERD	14. NAME OF HUSBAND OR WIFE INA
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 500-09-8853	17. INFORMANT INA STOKES	Address MARSHFIELD MO
--	---	------------------------------------	---------------------------------

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
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) DECOMPENSATED HYPERTENSIVE HEART DISEASE	
	DUE TO (c) ARTERIOSCLEROSIS	

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.)
---	--

20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <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 Death occurred at 5/21/58 to 2/8/59 and last saw him alive on 2/8/59 6:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) J. E. Blair, M.D.	22b. ADDRESS 2 Marshfield, Mo.	22c. DATE SIGNED 2/10/59
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2-11-1959	23c. NAME OF CEMETERY OR CREMATORY MARSHFIELD	23d. LOCATION (City, town, or county) (State) MARSHFIELD MO
--	-------------------------------	---	---

24. FUNERAL DIRECTOR BARBER-EDWARDS	ADDRESS MARSHFIELD	25. DATE RECD. BY LOCAL REG. FEB 13 1959	26. REGISTRAR'S SIGNATURE J. E. Blair
---	------------------------------	--	---

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 *Gene C. Hunter*

Licensed Embalmer No. *4739*

P. O. Address *Spokane, Idaho*

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.