

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**59-018512**  
STATE FILE NUMBER

Registration District No. 241 Primary Registration District No. 5828 Registrar's No. 15

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>NEW MADRID</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	a. STATE <b>MISSOURI</b>	b. COUNTY <b>Remiseot</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>LESTIEUR TWP.</b>	c. CITY OR TOWN <b>PORTAGEVILLE</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3</b>	Length of stay in 1b	d. STREET OR ADDRESS <b>078 ROUTE # 2</b>	(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)	First <b>ROY</b>	Middle <b>CLYDE</b>	Last <b>STEPHENS</b>	<b>4. DATE OF DEATH</b>	Month <b>MAY</b>	Day <b>31</b>	Year <b>1959</b>
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<b>5. SEX</b> <b>MALE</b> 0	<b>6. COLOR OR RACE</b> <b>WHITE</b> 0	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>MARCH 1, 1936</b>	<b>9. AGE</b> (In years last birthday) <b>23</b>	<b>F UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>EAST PRAIRIE, Mo. 0</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>SAM STEPHENS</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>JEWELL BRANTLEY</b>	<b>14. NAME OF HUSBAND OR WIFE</b>
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<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <b>YES</b>	<b>16. SOCIAL SECURITY NO.</b> <b>496-40-0430</b>	<b>17. INFORMANT</b> <b>SAM STEPHENS</b>	<b>Address</b> <b>PORTAGEVILLE, MISSOURI</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>AUTOMOBILE ACCIDENT--BRAIN CONCUSSION AND</b> <b>BROKEN NECK</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	<b>INTERVAL BETWEEN ONSET AND DEATH</b>
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<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year	<b>20d. INJURY OCCURRED WHILE AT</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> <b>072</b>	<b>COUNTY</b>	<b>STATE</b>
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**21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_**  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <i>Edw Hulynock</i> 0	(Degree or title)	<b>22b. ADDRESS</b> <b>New Madrid, Mo.</b>	<b>22c. DATE SIGNED</b> <b>5/31/59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>	<b>23b. DATE</b> <b>JUNE 2, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>CHARLESTON CEMETERY</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>CHARLESTON MISSOURI</b>
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<b>24. FUNERAL DIRECTOR</b> <b>DELISLE FUNERAL PARLOR PORTAGEVILLE, MO.</b>	<b>ADDRESS</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>6-6-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Edw Hulynock</i>
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Health, Welfare & Public Service  
 300  
 1-57  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with any disease. All diseases in Part I must be causally related.

JUN 16 1959

*J. J. S.*

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 *Joseph A. ...* .....  
Licensed Embalmer No. 4481 .....

P. O. Address Portageville, 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.