

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-028166

FILED VS AUG 17 1959

3006

354

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Bonne</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bonne</u>															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in lb <u>24 hours</u>		c. CITY OR TOWN <u>Columbia</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>University Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>908 E. Walnut</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ray Morrison Stokes</u>						4. DATE OF DEATH Month Day Year <u>Aug 12 1959</u>													
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</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>10-20-94</u>		9. AGE (last birthday) <u>64</u>		IF UNDER 1 YEAR Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>commercial artist</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>ADVERTISING</u>		11. BIRTHPLACE (City and state or country) <u>Kansas City Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>												
13a. FATHER'S NAME <u>Jacob D Stokes</u>			13b. MOTHER'S MAIDEN NAME <u>Leannette Ross</u>			14. NAME OF HUSBAND OR WIFE <u>Margaret Stokes</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>486-03-9962</u>		17. INFORMANT <u>Hospital chart Univ. Hospital</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>CARCINOMA OF THE LUNG WITH METASTASES</u>										INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) _____									
DUE TO (c) _____										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
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 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. Month, Day, Year _____		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 <u>8/11/59</u> to <u>8/12/59</u> and last saw him alive on <u>8/11/59</u> Death occurred at <u>3:50</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <u>J. J. Sanders MD</u> (Degree or title)						22b. ADDRESS <u>Univ of Mo. Med Center</u>				22c. DATE SIGNED <u>8/12/59</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Aug 12 59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>				23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>											
24. FUNERAL DIRECTOR <u>Parsons Funeral Service, Columbia, Mo</u>						25. DATE RECD. BY LOCAL REG. <u>Aug 12 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u>											

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 25 1959

SEP 20 1959

AUG 28 1959

VS MAY 19 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed George A. Keeby

Licensed Embalmer No. 4752

P. O. Address Calumet

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.