# MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS AUG 18 1959

59-031331
STATE FILE NUMBER

Registration District No. 374 Primary Registration District No. _____ Registrar's No. 28

DED

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DOCUMENT

**1. PLACE OF DEATH**
a. COUNTY: Worth County
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Sheridan Missouri
Length of stay in 1b: 75 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: south west part
Inside Limits: Yes [X] No [ ]

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Worth
c. CITY OR TOWN: Sheridan Missouri
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): South West Part
Reside on Farm: Yes [ ] No [X]

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| Amanda | Almeda | Stone | July | 25 | 1959 |

| 5. SEX | 6. COLOR OR RACE | 7. Married / Never Married / Widowed / Divorced | 8. DATE OF BIRTH | 9. AGE (last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HR Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | Widowed [X] | July-7-1870 | 89 | | 18 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| housewife | housewife | Adams County Ohio | U.S.A. |

| 13a. FATHER'S NAME | 13b. MOTHER'S MAIDEN NAME | 14. NAME OF HUSBAND OR WIFE |
|---|---|---|
| John W. Florea | Cynthia Powell | William A. Stone |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| no | none | none | Mrs Victor Stone, Sheridan Missouri |

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 10yrs
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)

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

| 19. WAS AUTOPSY PERFORMED? | 20a. ACCIDENT | SUICIDE | HOMICIDE | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
|---|---|---|---|---|
| YES [ ] NO [X] | [ ] | [ ] | [ ] | |

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 1957, to July 25, 1959 and last saw her/him alive on July 25, 1959
Death occurred at 1 am/pm on the date stated above, and to the best of my knowledge, from the causes stated.

| 22a. SIGNATURE (Degree or title) | 22b. ADDRESS | 22c. DATE SIGNED |
|---|---|---|
| Frank B Matteson M D | Grant City Mo | 7/25/59 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | July 26-59 | Osburg Cemetery | Osburg Mo |

| 24. FUNERAL DIRECTOR | ADDRESS | 25. DATE RECD. BY LOCAL REG. | 26. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| John Anderson | Grant City Mo | Aug 12-1959 | Bowday Kibbe |

(Licensed Embalmer's Statement on Reverse Side)

**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 L. A. Rhoades, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed L. A. Rhoades

Signature of Student Embalmer

Licensed Embalmer No. 4 7 5 [illegible]

P. O. Address Mt Ayr[illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.