

FILED VS SEP 29 1959

Registration District No. 74 Primary Registration District No. 4136 Registrar's No. 34

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Plattsburg</u>			Length of stay in 1b		c. CITY OR TOWN <u>Plattsburg</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>500 Osage St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>500 Osage St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Cammie</u> Middle <u>None</u> Last <u>Stufflebean</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Female</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>3/6/1884</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Camden Point Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>J. D. Keller</u>			13b. MOTHER'S MAIDEN NAME <u>Frances Deets</u>		14. NAME OF HUSBAND OR WIFE <u>Thomas Stufflebean</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>NONE</u>		17. INFORMANT <u>Thomas Stufflebean Plattsburg MO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Myocarditis</u>							<u>3 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <u>Herpes zoster</u>							<u>2 months</u>
DUE TO (c) <u>Gastrointestinal inflammation</u>							<u>4 months</u>
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 d. s <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 15.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ 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 <u>May 5</u> to <u>Sept 16</u> and last saw her <u>Sept 16</u> alive on <u>Sept 16</u> Death occurred at <u>Sept 17</u> hour <u>unknown</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>M. V. Hayward, D.D.</u>				22b. ADDRESS <u>Plattsburg, Mo.</u>		22c. DATE SIGNED <u>Sept 19, 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Sept 20 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>Plattsburg Missouri</u>		
24. FUNERAL DIRECTOR <u>Lyon Funeral Home Inc. Plattsburg MO</u>				25. DATE RECD. BY LOCAL REG. <u>9-20-59</u>		26. REGISTRAR'S SIGNATURE <u>Mary W Seearce</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Wiley E. Cox

Licensed Embalmer No. 4793

P. O. Address Stonewall,

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