

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000230

FILED VS JAN 25 1960 8

Registration District No. \_\_\_\_\_ Primary Registration District No. 3006 Registrar's No. 28

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Hawell</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>37 Days</b>		c. CITY OR TOWN <b>West Plains</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MO. Medical Center</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1014 W. 6<sup>th</sup> St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>VARGIE</b> Middle <b>M<sup>rs</sup> CLARE</b> Last <b>STEPHENS</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>18</b> Year <b>60</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-22-1900</b>	9. AGE (last birthday) <b>59</b>	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) <b>AT HOME</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (City and state or country) <b>ARKANSAS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S</b>		
13a. FATHER'S NAME <b>J. T. M<sup>rs</sup> CLARE</b>			13b. MOTHER'S MAIDEN NAME <b>Dona Bunch</b>			14. NAME OF HUSBAND OR WIFE <b>CLAUDE STEPHENS</b>			
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 <b>University of Mo. Medical Records</b>			Address	
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) <b>Ventricular fibrillation</b>									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) <b>Hypovolemic anoxia</b>		
							DUE TO (c) <b>MI + Hemorrhage</b>		
PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal condition given in PART I (a) <b>Diabetes Mellitus</b> <b>Carcinoma of duodenum, with metastasis to lymph nodes</b>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" 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 <b>12-19-59</b> to <b>1-18-60</b> and last saw her alive on <b>1-18-60</b> Death occurred at <b>11:22 PM</b> <b>1-18-60</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>John Keith Logan M.D.</b>				22b. ADDRESS <b>Columbia Mo.</b>		22c. DATE SIGNED <b>1-19-60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1-22-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAUREL HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ST LOUIS, MO.</b>					
24. FUNERAL DIRECTOR <b>Parson Funeral Service, Columbia Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>Jan 19, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmar</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 2

**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 \_\_\_\_\_

*J. W. Phelby*

Licensed Embalmer No. *4897*

P. O. Address *Columbus*

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.