

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS **OCT 24 1960**

71

Primary Registration District No. **3012**

Registrar's No. **98**

-60-037779

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Clay				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay								
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs		Length of stay in 1b 14 yrs		c. CITY OR TOWN Excelsior Springs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Excelsior Springs Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 503 N. Kimball		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Vivian Middle Stevens Last Stevens				4. DATE OF DEATH Month October Day 6 Year 1960								
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11-16-1919	9. AGE (last birthday) 40	IF UNDER 1 YEAR Months 10 Days 0 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Maryville, Missouri		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME James A. Smith			13b. MOTHER'S MAIDEN NAME Stella E. Cozad			14. NAME OF HUSBAND OR WIFE Dr. Howard M. Stevens						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 488-14-4769		17. INFORMANT Dr. H. M. Stevens, 503 N. Kimball, Excelsior Springs, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Standstill							INTERVAL BETWEEN ONSET AND DEATH 3 MIN.					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Paroxysmal Auricular Flutter							3 HRS.					
DUE TO (c) Valvular Heart Disease Class IV D							15 Yrs.					
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. <input type="checkbox"/> Yes <input checked="" 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 18.)								
20c. TIME OF INJURY Hour 10:10 AM Month, Day, Year 1-1-52		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 1-1-52 to 10-6-60 and last saw her/him alive on 10-6-60 Death occurred at 1:10 AM on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE Dawn Musgrave M.D. (Degree or title)						22b. ADDRESS Excelsior Springs, Mo.				22c. DATE SIGNED 10/7/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-7-60	23c. NAME OF CEMETERY OR CREMATORY Crown Hill			23d. LOCATION (City, town, or county) Excelsior Springs, Mo.			(State)			
24. FUNERAL DIRECTOR Prichard Funeral Home, Inc. Excelsior Springs, Missouri (Licensed Embalmer's Statement on Reverse Side)					25. DATE RECD. BY LOCAL REG. 10-10-60		26. REGISTRAR'S SIGNATURE Caroline Hutchings					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 20 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

Ludice Jarmon

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

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