

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002043

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 2035 Registrar's No. 3

FILED VS JAN 11 1961

AMENDED

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Length of stay in lb <u>7 Yr.</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) OF STATE <u>Missouri</u> OF COUNTY <u>Lafayette</u>		c. CITY OR TOWN <u>Lexington</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>1128 Franklin</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1128 Franklin</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Christian Stephan</u>						4. DATE OF DEATH Month Day Year <u>January 2 1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>April 12, 1899</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>River Engineers</u>		11. BIRTHPLACE (City and state or country) <u>Wellington, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		
13a. FATHER'S NAME <u>Christian Stephan</u>			13b. MOTHER'S MAIDEN NAME <u>Helena Apprill</u>			14. NAME OF HUSBAND OR WIFE <u>unknown</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>INFORMANT</u> Address <u>Mrs. Joyce Bryant, Wellington, Mo</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>Natural cause of death</u> DUE TO (b) <u>Chronic alcoholism and</u> DUE TO (c) <u>inflammation.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Very emaciated.</u>						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		
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 Month, Day, Year p.m.								
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 <u>after death on 1-2-61</u> and last saw <u>her</u> alive on <u>never</u> Death occurred at <u>about 1 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>W. Martin MD Coroner</u> (Degree or title)				22b. ADDRESS <u>Ocala Mo</u>		22c. DATE SIGNED <u>1-2-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 5, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wellington Cemetery</u>		23d. LOCATION (City, town, or county) <u>Wellington, Mo</u> (State)		
24. FUNERAL DIRECTOR <u>Vaughn-Walker Lexington, Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>1-4-61</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. E. Eastbrook</u>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

JAN 12 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed David L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington, Va

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.