

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-036429

STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. Registrar's No. 107

FILED NOV 13 1961

1. PLACE OF DEATH a. COUNTY Dent County				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Watkins TWP		Length of stay in 1b 10 yr		c. CITY OR TOWN Lenox, Missouri		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Watkins TWP,			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Lenox, Missouri		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Georgia Bell Stites				4. DATE OF DEATH Month Day Year November 6, 1961				
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 Sept. 3, 1883	9. AGE (last birthday) 78	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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Housekeeping	11. BIRTHPLACE (City and state or country) Dent County, Mo		12. CITIZEN OF WHAT COUNTRY U. S. A		
13a. FATHER'S NAME David Davidson			13b. MOTHER'S MAIDEN NAME Amanda Wofford		14. NAME OF HUSBAND OR WIFE Emmette Stites			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No <input type="checkbox"/> X <input checked="" type="checkbox"/>			16. SOCIAL SECURITY NO. X	17. INFORMANT Emmette Stites, Lenox, Mo. Address				
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>Cardiac + pulmonary arrest</u> DUE TO (b) <u>Circulatory collapse</u> DUE TO (c) <u>Severe Cerebrovascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive heart disease</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 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 <u>1955</u> to <u>1961</u> and last saw her <sup>him</sup> alive on <u>Nov. 6, 1961</u> Death occurred at <u>1:30 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>B. J. Myers D.O.</u> (Degree or title)				22b. ADDRESS <u>Licking, Mo.</u>		22c. DATE SIGNED <u>11-8-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 9, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Enke, Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lenox, Missouri</u>			
24. FUNERAL DIRECTOR <u>SPENCER FUNERAL HOME INC. SALEM, MO</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>11/7/61</u>		26. REGISTRAR'S SIGNATURE <u>M. M. [Signature]</u>		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO.  
SHOULD READ

a.

**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 D. Dumm

Licensed Embalmer No. 2371

P. O. Address Palm

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.