

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-021613

STATE FILE NUMBER

Registration District No. 326 Primary Registration District No. _____ Registrar's No. 77

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 4 1962	
1. PLACE OF DEATH a. COUNTY <u>Scotland</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Memphis</u> Length of stay in lb <u>20 years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scotland</u> c. CITY OR TOWN <u>Memphis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Belle Stivers</u>	
4. DATE OF DEATH Month Day Year <u>May 24, 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27, 1882</u>
9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (City and state or country) <u>Fairfield, Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>G. K. Davis</u>	13b. MOTHER'S MAIDEN NAME <u>Rachel Murphy</u>
14. NAME OF HUSBAND OR WIFE <u>Will Stivers</u>	17. INFORMANT <u>Pearl Stivers</u> Address <u>Memphis, Missouri</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>no</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>Acute circulatory failure</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ 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 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 _____ 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>July 23, 1956</u> to <u>May 23, 1962</u> and last saw her alive on <u>May 23, 1962</u> Death occurred at <u>4:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Wm H. Duvall D.O.</u>	22b. ADDRESS <u>230 So. Market Memphis, Missouri</u>
22c. DATE SIGNED <u>5-29-62</u>	23d. LOCATION (City, town, or county) (State) <u>Memphis, Missouri</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 26, 1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Memphis Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Memphis, Missouri</u>
24. FUNERAL DIRECTOR <u>GERTH & BASKETT MEMPHIS, MISSOURI</u>	25. DATE RECD. BY LOCAL REG. <u>5-29-62</u>
26. REGISTRAR'S SIGNATURE <u>Wm H. Duvall</u>	

VS 300 Rev. 4/59
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

