

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-022410

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. 77

Primary Registration District No. 3066

Registrar's No. 250

FILED JUN 26 1962

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		c. CITY OR TOWN <u>Excelsior Springs</u>	
Length of stay in lb <u>3 Hours</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>Still Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Route 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Jeffrey</u> Middle <u>Edward</u> Last <u>Stein</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23-62</u>
9. AGE (last birthday) <u>6</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Camdenton Mo</u>
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <u>Darrel Stein</u>	
13b. MOTHER'S MAIDEN NAME <u>Lois Jean Poules</u>		14. NAME OF HUSBAND OR WIFE	
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 <u>Darrel Stein</u>		Address <u>Excelsior Springs 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>Medullary Paralysis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Respiratory Failure</u> DUE TO (c) <u>Premature birth</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 hour</u> <u>4 months 0</u>
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 type="checkbox"/>	20a. ACCIDENT <input checked="" 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 <u>7:00 pm</u> a.m. <u>6/24/62</u> Month, Day, Year <u>6/24/62</u> 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>7:00 pm 6/23/62</u> to <u>3:00 6/24/62</u> and last saw her/him alive on <u>6/24/62</u> Death occurred at <u>3:00 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Kenneth E. Witzlum D.D.</u>		22b. ADDRESS <u>Camdenton, Mo</u>	22c. DATE SIGNED <u>6/24/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 26, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Excelsior Springs Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs Mo</u>
24. FUNERAL DIRECTOR <u>Robert H. Reed, Camdenton Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>24 June 1962</u>	26. REGISTRAR'S SIGNATURE <u>R.P. Davis, M.D. T. Richter, M.D.</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

VS 300 Rev. 4/59
 10269
 26000
 3
 4 0
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 9773.5
 10
 11
 12 1-2
 13 1-0
 USE BLACK INK OR TYPEWRITER RIBBON

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address Camdenton Mo.

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.