

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-047544

STATE FILE NUMBER

Registered District No. 476 Primary Registration District No. 5638 Registrar's No. 39

FILED DEC 21 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Lafayette</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sniabar twns</b>		Length of stay in lb <b>6 Mos.</b>	c. CITY OR TOWN <b>Near Odessa</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>7 Mi. South of Odessa</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7 Mi. South of Odessa</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sallie Catherine Stone</b>			4. DATE OF DEATH Month Day Year <b>December 13, 1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-3-85</b>
9. AGE (last birthday) <b>77</b>		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) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Carroll Co., Mo.</b>
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <b>James Wm. Dixon</b>	13b. MOTHER'S MAIDEN NAME <b>Cora Wheat</b>
14. NAME OF HUSBAND OR WIFE <b>Samuel G. Stone (dec)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>
17. INFORMANT Address <b>Mrs. Irene C. Taggart, Odessa, Mo.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <b>Cerebral Vascular Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 years</b>	
DUE TO (c)		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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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>11-6-61</u> to <u>12-13-62</u> and last saw her <sup>her</sup> <del>him</del> alive on <u>12-12-62</u> . Death occurred at <u>11:45</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Wayne Boynton MD</b>		22b. ADDRESS <b>107 302nd St Odessa Mo.</b>	22c. DATE SIGNED <b>12-19-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 15, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hale Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hale, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Husman-Sparks Odessa, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-15-1962</b>	26. REGISTRAR'S SIGNATURE <b>Emma Davidson</b>

**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 William F. Sparks

Licensed Embalmer No. 4431

P. O. Address Oessa, 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.