

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031441
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1075

FILED SEP 11 1963

DO NOT WRITE ON THIS STUB	AMENDED				
VS 300 Rev. 4/59	DATE AMENDED				
1 <u>5117</u>	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS				
2 <u>8050</u>	INSTEAD OF				
3	DOCUMENT				
4 <u>0</u>	BY AFFIDAVIT OF				
5 <u>3</u>	W.H. Ames, M.D., Physician				
6	CERTIFICATION				
7 <u>1</u>	SHOULD READ				
8 <u>2</u>	ITEM NO.				
9 <u>9451X</u>	TYPEWRITER RIBBON				
10					
11					
12 <u>2-c</u>					
13 <u>1-a</u>					

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Colorado</u> b. COUNTY <u>Rio Grande</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph,</u>		Length of stay in lb <u>3 Months</u>	c. CITY OR TOWN <u>Monte Vista,</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>Meth. Hosp. & Med. Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>18 Davis Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>RAY</u> Last <u>STEPHENS</u>			4. DATE OF DEATH Month <u>September</u> Day <u>1,</u> Year <u>1963</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 25, 1887</u>
9. AGE (last birthday) <u>76</u>		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) <u>Ret. Farm Implement Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Del Norte, Colorado</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Joseph Stephens</u>	
13b. MOTHER'S MAIDEN NAME <u>Nancy Jane Clark</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Mae Stephens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Army (Peacetime)</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT Address <u>Mrs. James H. Gaines-St. Joseph, Missouri</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Red Rupt abdominal aneurysm</u> DUE TO (b) <u>dissecting abdominal aneurysm</u> DUE TO (c) <u>Atherosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>inst.</u> <u>+ 5 day</u> <u>inst.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ASIA</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 _____ 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>8-27-63</u> to <u>9-1-63</u> and last saw him alive on <u>8-31-63</u> Death occurred at <u>4:10 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William H. Ames, M.D.</u>		22b. ADDRESS <u>952 Edmond</u>	22c. DATE SIGNED <u>9-3-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Sept. 1, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>W. Edward Sharp Fun'l Home</u>	23d. LOCATION (City, town, or county) (State) <u>Monte Vista, Colorado</u>
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Sept. 9, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>	

SEP 12 1963

R 80204
P 117

Permit issued 9-2-63

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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 Edward E. Harrington

Licensed Embalmer No. 2708

P. O. Address St. Joseph, 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.