

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22911

State File No.

BIRTH NO. _____ REG. DIST. NO. 83 PRIMARY REG. DIST. NO. 4145 Registrar's No. 16

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>COOPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>COOPER</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>PRairie HOME Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>PRairie HOME Mo</u>	
c. LENGTH OF STAY (in this place) <u>10 YEARS</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>PRairie HOME Mo</u>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES T.</u> b. (Middle) <u>STEPHENS</u> c. (Last) <u>STEPHENS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 31-1949</u>		
--	--	--	---	--	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MARCH 22-1860</u>	9. AGE (in years last birthday) <u>89</u>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	
13a. FATHER'S NAME <u>KEMP STEPHENS</u>			13b. MOTHER'S MAIDEN NAME <u>HULDA FENEROW</u>		14. NAME OF MARRIAGE OR WIFE <u>BETTIE STEPHENS</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>		17. INFORMANT'S SIGNATURE OR NAME <u>Bettie Stephens</u> ADDRESS <u>Home Mo</u>	
--	--	------------------------------------	--	---	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u> ANTECEDENT CAUSES As forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Angina Pectoris</u> DUE TO (c) <u>Atherosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
--	--	--	--	--	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from July 31, 1949, to July 31, 1949, that I last saw the deceased alive on July 31, 1949, and that death occurred at 4:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Type or Print) <u>T. R. Dickerson M.D.</u>	23b. ADDRESS <u>Bronside Mo</u>	23c. DATE SIGNED <u>8/1/49</u>
--	---------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>Aug 31 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>GREENRIDGE CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>GREENRIDGE Mo.</u>
--	------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>8/2/49</u>	REGISTRAR'S SIGNATURE <u>U. F. Meredith</u>	72	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Albert Hombek</u> ADDRESS <u>Prarie Home</u>
--	---	----	---

RECEIVED AUG 6 REC'D
District Health Officer No. 8,

District File Number: _____

Date Filed: 8-12-49

AUG 7 1949

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 _____
Student Embalmer

Signed To Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prarie Home md

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 this body is not embalmed, fact should be so stated above.