

FILED MAR 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43990

BIRTH NO. _____		REG. DIST. NO. 141		PRIMARY REG. DIST. NO. 3025		Registrar's No. 22		
1. PLACE OF DEATH a. COUNTY <u>Newell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Newell</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>West Plains</u>		c. LENGTH OF STAY (If in this place) <u>1 1/2</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Tomona, Mo</u> 0430				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christa Nazare Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>Rt.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>Elizabeth</u> c. (Last) <u>Stein</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>12-29-50</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED NEVER MARRIED, WIDOWED DIVORCED (Specify) <u>W</u>		8. DATE OF BIRTH <u>11-27-1876</u>		
9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>				
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 <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Kelyde, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Stein</u>			13b. MOTHER'S MAIDEN NAME <u>Wendy</u>		14. NAME OF HUSBAND OR WIFE <u>Michael Stein</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></u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>M. Stein, Tomona 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>					4222	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)		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 <u>4-18</u> , 19 <u>49</u> , to <u>12-29</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>12-29</u> , 19 <u>50</u> , and that death occurred at <u>1:00</u> m., from the causes and on the date stated above.								
23a. SIGNATURE <u>Ch. Callahan M.D.</u> (Degree or title)				23b. ADDRESS <u>West Plains, Mo.</u>		23c. DATE SIGNED <u>1-6-51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>12-2-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		24d. LOCATION (City, town, or county) (State) <u>White Church</u>		
DATE REC'D BY LOCAL REG. <u>3-13-51</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Robertson</u>		ADDRESS <u>West Plains Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

DIVISION OF HEALTH NO.
District No. 5000

RECEIVED MAR 19 1951

Dist. File 357-609

Date Filed 3-22-51

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.

Signed D. D. Robertson

Signed.....
Student Embalmer

Licensed Embalmer No. 3437

P. O. Address West Plains, 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 this body is not embalmed, fact should be so stated above.