

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32689**

FILED OCT 15 1951

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1041

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. LENGTH OF STAY (In this place) 20 yrs		d. STREET ADDRESS (If rural, give location) 2619 Penn Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Methodist Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) Milton	c. (Last) Stephen	4. DATE OF DEATH (Month) (Day) (Year) October 3, 1951.
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 10, 1874	9. AGE (In years) (Months) (Days) 77	IF UNDER 1 YEAR 0 IF UNDER 15 HRS. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Distributor	10b. KIND OF BUSINESS OR INDUSTRY Electrical Supplies	11. BIRTHPLACE (State or foreign country) Harrisburg, Penn.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Jacob Stephen	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Katherine Stephen
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 500-20-9427	17. INFORMANT'S SIGNATURE OR NAME Mrs. Katherine Stephen	ADDRESS St. Joseph, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs sync 2
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Abdominal aneurysm		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Pleurisy, Pancreatitis, Acute - Recurrent			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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)
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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?
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22. I hereby certify that I attended the deceased from 9/26, 1951, to 10/3, 1951, that I last saw the deceased alive on 10/3, 1951, and that death occurred at 1:10 P m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i> (Degree or title)	23b. ADDRESS St. Joseph Mo	23c. DATE SIGNED 10/5/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE October 5, 1951	24c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. October 11, 1951	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS St. Joseph, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0117

OCT 24 1951

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, of *****

***** Student Embalmer No. *****

working under my personal supervision.

Signed Elbert C. Harrington

Signed
*** Student Embalmer

Licensed Embalmer No. 3258 Missouri.

P. O. Address St. Joseph, Missouri.

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.