

FILED MAY 31 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14646

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>124</u>		
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>				
b. CITY OR TOWN <u>Columbia</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Hallsville</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>				STREET ADDRESS (If rural, give location) <u>Rural Route 2</u> <u>0200</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Jessie</u> b. (Middle) <u>Ann</u> c. (Last) <u>Stephens</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 22 1955</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 24, 1897</u>		
9. AGE (In years last birthday) <u>57</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>28</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 _____			11. BIRTHPLACE (City and State or Foreign Country) <u>Audrain County Mo.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>Taylor Trimble</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Day</u>		14. NAME OF HUSBAND OR WIFE <u>Champ 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 ADDRESS <u>Champ Stephens, Rte 2, Hallsville, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>331X</u> 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>36 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) _____		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>5-21 1955</u> to <u>5-22 1955</u> , that I last saw the deceased alive on <u>5-22 1955</u> , and that death occurred at <u>11:35 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>R.P. Johnson MD</u> (Degree or title)				23b. ADDRESS <u>Columbia Mo</u>		23c. DATE SIGNED <u>5-24-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>May 25, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Church of Christ</u>		24d. LOCATION (City, town, or county) (State) <u>near Hallsville, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>May 24 1955</u>		REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bill E. Meador</u>		ADDRESS <u>Centelia, Missouri</u>		

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

JAN 2 1976

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 *Bill J. Meador*

Licensed Embalmer No. *4876*
P. O. Address *Centerville, 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.