

FILED FEB 17 1956

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

 State File No. **7252**
1343

318

1003

Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 7252 1343		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Texas				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN Licking		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 BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) 1011				
3. NAME OF DECEASED (Type or Print) a. (First) Bernard b. (Middle) MMN c. (Last) Stair			4. DATE OF DEATH (Month) (Day) (Year) Feb. 6, 1956					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 30, 1896		
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months _____		IF UNDER 2 HRS. Hours _____		IF UNDER 4 MIN. Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Postal Employee			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Freeman, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME J.H. Stair			13b. MOTHER'S MAIDEN NAME Cordelia Miller			14. NAME OF HUSBAND OR WIFE Hallie		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1		17. INFORMANT'S SIGNATURE OR NAME Hallie Stair, Licking, Mo.		ADDRESS _____		
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) Duodenal ulcer (Duodenal ulcer) ANTECEDENT CAUSES Morbid 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. Post-operative pancreatitis					INTERVAL BETWEEN ONSET AND DEATH Years 20-25 days	
19a. DATE OF OPERATION 1-9-56		19b. MAJOR FINDINGS OF OPERATION Duodenal ulcer Post Operative pancreatitis					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) 541.0				
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 Dec. 29, 1955 to Feb. 6, 1956 , that I last saw the deceased alive on Feb. 6, 1956 , and that death occurred at 3:45 PM from the causes and on the date stated above.								
23a. SIGNATURE B. Harper <i>Clarence B. Harper</i>				23b. ADDRESS BARNES HOSPITAL M.D.		23c. DATE SIGNED 2/6/56		
24a. BURIAL CREMATION REMOVAL (Specify) Removal		24b. DATE 2-7-56		24c. NAME OF CEMETERY OR CREMATORY Local		24d. LOCATION (City, town, or county) (State) Licking, Mo.		
DATE REC'D BY LOCAL REG. FEB 7 1956		REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.				

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 20 1956

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 *Stanley H. Wilson*.....

Licensed Embalmer No. *419*.....

P. O. Address *SL*.....

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.