

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED DEC 30 1957

44847  
 STATE FILE NUMBER

Registration District No. 155 Primary Registration District No. 4245 Registrar's No. 217

V. S. 300  
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>JASPER</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JASPER</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) ORONOGO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ORONOGO		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BOX HOLDER</b>		Length of stay in lb <b>LIFETIME</b>	d. STREET ADDRESS (If outside, give location) <b>BOX HOLDER</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BRICK</b> Middle <b>P.</b> Last <b>STULTS</b>			4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>19</b> Year <b>1957</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 14, 1869</b>	9. AGE (In years : last birthday) <b>88</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MINING</b>	11. BIRTHPLACE (City and state or country) <b>ORONOGO, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>AL STULTS</b>		13b. MOTHER'S MAIDEN NAME <b>CINTHIA NIXON</b>		14. NAME OF HUSBAND OR WIFE <b>FANNIESTULTS (DECEASED)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>MRS ROLLON LACY, OGDON, UTAH</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 years.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Benign tumor of mediastinum</b>		DUE TO (c) <b>20 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>212X</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>7-10-50</b> to <b>12-19-57</b> and last saw <sup>her</sup> him alive on <b>12-18-57</b> Death occurred at <b>1:30 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Dr. M. Ferguson, M.D.</b>			22b. ADDRESS <b>Webb City Mo.</b>		22c. DATE SIGNED <b>12/19/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12-22-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ORONOGO CEMETARY</b>		23d. LOCATION (City, town, or country) (State) <b>ORONOGO, MISSOURI</b>	
24. FUNERAL DIRECTOR <b>HEDGE-LEWIS FUNERAL HOME</b>		ADDRESS <b>WEBB CITY MO</b>	25. DATE RECD. BY LOCAL REG. <b>12-21-57</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Madeline Sirtgen</b>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 Richard Gray Lewis

Licensed Embalmer No. 4403

P. O. Address Webb City, 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.