

Dept. Health,
ec., & Welfare
U. S. Public
Health Service

FILED JAN 2 1958

STANDARD CERTIFICATE OF DEATH

45024

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 5696 Registrar's No. 23

V. S. 300
Rev. 1-57

Dr. Lewis

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

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural-Jackson Twp.		c. CITY OR TOWN Chillicothe	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7 mi. N.W. Chillicothe		Length of stay in 1b 6wks.	
d. STREET ADDRESS 1000 Washington		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Miner Middle C. Last Stevens			4. DATE OF DEATH Month Dec. Day 18 Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	11. BIRTHPLACE (City and state or country) Livingston Co., Mo.
13a. FATHER'S NAME James B. Stevens		13b. MOTHER'S MAIDEN NAME Emma Allen	14. NAME OF HUSBAND OR WIFE XX
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. 488-14-4417	17. INFORMANT Address Wilbur Stevens, Chillicothe, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5702			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.)	
20c. TIME OF INJURY .Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Sept. 1957 to 17 Dec. 1957 and last saw ^{her} alive on 17 Dec. 1957 Death occurred at 4:55 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Charles M. Trace, M.D. (Degree or title)		22b. ADDRESS Chillicothe, Mo.	
		22c. DATE SIGNED 19 Dec. 1957	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Dec. 20, 1957	23c. NAME OF CEMETERY OR CREMATORY Jamesport cemetery
		23d. LOCATION (City, town, or county) (State) Jamesport, Mo.	
24. FUNERAL DIRECTOR Donald Gordon, Chillicothe, Mo.		25. DATE RECD. BY LOCAL REG. Dec 20 / 57	26. REGISTRAR'S SIGNATURE Frances B. Neill

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JAN 15 1958

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 K. Bandall*

Licensed Embalmer No. *4866*

P. O. Address *Pulaski, 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.