

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013500  
STATE FILE NUMBER

FILED APR 17 1958

Registration District No. 53

Primary Registration District No. 3011

Registrar's No. 257

300  
-570

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cape Girardeau</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cape Girardeau</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Daisy Mo</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>S E Mo Hospital</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>No Street</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Louise</b> Last <b>Stearns</b>	4. DATE OF DEATH Month <b>April</b> Day <b>3m</b> Year <b>1958</b>
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5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 1 1871</b>	9. AGE (In years) 87 (birthday)	IF UNDER 1 YEAR Months <b>3</b> Days <b>2</b>	IF UNDER 24 HRS. Hours <b>2</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Arnsburg Mo</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
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13a. FATHER'S NAME <b>Henry Kaiser</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Olemmons</b>	14. NAME OF HUSBAND OR WIFE <b>Chap Stearns</b>
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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)	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs Alvin Sauer Friedhime Mo</b>	Address
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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>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	<b>331X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Coronary Artery Disease</b>		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from **2-19-58**, to **4-3-58** and last saw her/him alive on **4-3-58**  
Death occurred at **11:00** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>E. F. McDonald, M.D.</b> (Degree or title)	22b. ADDRESS <b>Jackson Mo.</b>	22c. DATE SIGNED <b>4-9-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Apr 5 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Salem</b>	23d. LOCATION (City, town, or county) (State) <b>Daisy Mo</b>
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24. FUNERAL DIRECTOR <b>McCombs Funeral Home</b>	ADDRESS <b>Jackson Mo</b>	25. DATE RECD. BY LOCAL REG. <b>April 11, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Mr. Homer E. Cooper</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *B A Meyer* .....

Licensed Embalmer No. *3057* .....

P. O. Address *Jacksonville* .....

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.