

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043163

STATE FILE NUMBER

FILED JAN 13 1959

Registration District No. 4 Primary Registration District No.

Registrar's No. 104

S. 300 0
1-57

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fairfax</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Fillmore</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fairfax Community Hosp</u>			Length of stay in 1b <u>4 days</u>		d. STREET ADDRESS (If outside, give location) <u>2 1/2 Mi. S. Fillmore, Mo.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Hiram</u> Middle <u>Winfield</u> Last <u>Stinnett</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 9, 1876</u>		9. AGE (In years last birthday) <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Fordland, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Stennett</u>			13b. MOTHER'S MAIDEN NAME <u>Lucinda McDonald</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Jane Stennett</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>None</u>		17. INFORMANT Address <u>Cyril W. Stennett, Fillmore, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						4201	
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.)				
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 <u>July 1, 1953</u> to <u>Dec 31, 1958</u> and last saw him alive on <u>Dec 31, 1958</u> Death occurred at <u>5:30 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. J. Sweeney M.D.</u>				22b. ADDRESS <u>Oregon, Mo.</u>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-3-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fillmore City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Fillmore, Mo.</u>		
24. FUNERAL DIRECTOR <u>Wm A Rich, Savannah, Mo.</u>				ADDRESS <u>Savannah, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 6, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Harwin H Schaefer</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *Wm A Rich*

Licensed Embalmer No. *4228*
P. O. Address *Savannah, Ga*

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.