

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004997

STATE FILE NUMBER

FILED FEB 18 1959

Registration District No. 098

Primary Registration District No.

Registrar's No. 11

300
-57

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Rural Union Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Rural Union Township</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 1/2 Mi S. Gallatin</u>		Length of stay in lb <u>11 Yrs</u>	d. STREET ADDRESS (If outside, give location) <u>1 1/2 Mi. S. Gallatin</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Stephens</u>			4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>Female</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>March 6 1877</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Livingston Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>L. Dow Smith</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Litton</u>	14. NAME OF HUSBAND OR WIFE <u>Benjamin Stephens</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>N ne</u>	17. INFORMANT <u>Benjamin Stephens, Gallatin, Mo.</u>	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) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arterio-sclerosis</u>	
	DUE TO (c) <u>generalized unknown</u>	
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 <u>a.m.</u> Month, Day, Year <u>p.m.</u>	

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 <u>Gallatin Mo</u>	COUNTY <u>Daviess</u>	STATE <u>Missouri</u>
21. I attended the deceased from <u>Jan 9 1959</u> to <u>Feb 6 1959</u> and last saw her alive on <u>Feb 5, 1959</u> Death occurred at <u>3 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>Colwell B. Buser MD</u> (Degree or title)		22b. ADDRESS <u>Gallatin Mo</u>		22c. DATE SIGNED <u>2/8/59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-8-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lock Springs Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lock Springs, Missouri</u>
24. FUNERAL DIRECTOR <u>Hope Funeral Home</u>	ADDRESS <u>Gallatin, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>13 Feb. 1959</u>	26. REGISTRAR'S SIGNATURE <u>Regina Engelbert</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *L. O. Dickerson*

Licensed Embalmer No. *3307*
P. O. Address *Dallatney*

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.