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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-005341
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 19

1. PLACE OF DEATH
a. COUNTY Howard
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Fayette, Mo. Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Rhodes Nursing Home Length of stay in 1b 6 mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Howard
c. CITY OR TOWN Fayette 0451 0 Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 605 N. Church St. Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First EDNA Middle BYRON Last STOUFFER
4. DATE OF DEATH Month MAR. Day 5, Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]
8. DATE OF BIRTH Apr. 6, 1874
9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (City and state or country) Saline County, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William Freeman Senter
13b. MOTHER'S MAIDEN NAME Mary Swinney
14. NAME OF HUSBAND OR WIFE Charles Lester Stouffer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. None
17. INFORMANT Catherine Strickler Address Fayette, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Vertebral artery rupture — INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertension — 10 yrs.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none 444X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] 0

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) none
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 Jan. 10 1946, to Mar. 5-59 and last saw her alive on 3-5-59
Death occurred at 10 a.m. p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE [signature] (Degree or title) MD
22b. ADDRESS Fayette Mo.
22c. DATE SIGNED 3-6-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 3/7/1959
23c. NAME OF CEMETERY OR CREMATORY Ridge Park Cemetery
23d. LOCATION (City, town, or county) (State) Marshall, Missouri
24. FUNERAL DIRECTOR Ralph A. Carr ADDRESS Fayette, Mo.
25. DATE RECD. BY LOCAL REG. 3-6-59
26. REGISTRAR'S SIGNATURE Mary K. Shell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Ralph A. Carr

Licensed Embalmer No. 3340

P. O. Address Fayette, 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.