Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008063
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 323 Primary Registration District No. 4474 Registrar's No. 6

1. PLACE OF DEATH
a. COUNTY Saline
b. CITY OR TOWN Sweet Springs — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Forsyth Retorium — Length of stay in 1b: 8 months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Saline
c. CITY OR TOWN Salt Fork Twp. c770 c — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Napton RFD #2 — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First Nellie Middle Stewart Last Stouffer
4. DATE OF DEATH: Month Feb. Day 28 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 23, 1870
9. AGE (In years last birthday): 88 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): Howard, New York
12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME: Ambrose Stewart
13b. MOTHER'S MAIDEN NAME: Permillia Abbott
14. NAME OF HUSBAND OR WIFE: Leonard T. 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: Mrs. Crawford Stouffer Address: Napton, 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) Lobar pneumonia — 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): 490X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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 Nov 8 1958, to Feb 28, 1959 and last saw her alive on Feb 28, 1959
Death occurred at 3:20 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul A. Roberts (Degree or title) M.D.
22b. ADDRESS Sweet Springs, Mo
22c. DATE SIGNED 2-28-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-2-59
23c. NAME OF CEMETERY OR CREMATORY: Memorial Cemetery
23d. LOCATION (City, town, or county) (State): Saline County, Mo.

24. FUNERAL DIRECTOR: Campbell-Lewis ADDRESS: Marshall, Mo.
25. DATE RECD. BY LOCAL REG.: March 2, 1959
26. REGISTRAR'S SIGNATURE: Mary Moseley

(Licensed Embalmer's Statement on Reverse Side)

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

Paul A. Roberts M.D.

SEP 9 1963

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 .....

Licensed Embalmer No. 4709

P. O. Address .....

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.