

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017028
STATE FILE NUMBER

FILED MAY 19 1959 Registration District No. 56 Primary Registration District No. 5193 Registrar's No. 7

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR "Rural" Egypt Twp. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>"Rural" Egypt Twp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 1/2 mi. W. of Norborne</u> Length of stay in lb <u>40 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>1 1/2 mi. W. of Norborne</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BINTA</u> Middle <u>STEVENS</u> Last <u>STEVENS</u>			4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1959</u>
5. SEX <u>Fe.</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>Apr 30, 1884</u>
9. AGE (In years, last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </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	11. BIRTHPLACE (City and state or country) <u>Carroll Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>Amos Brice</u>	
13b. MOTHER'S MAIDEN NAME <u>LSusan Wolfskill</u>		14. NAME OF HUSBAND OR WIFE <u>D.M. Stevens</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> </u>	
17. INFORMANT <u>D.M. Stevens</u> Address <u>Norborne, 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>Congestive heart failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>7 mo</u>	
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.) <u>4341</u>	
20c. TIME OF INJURY .Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>		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>1 Apr 1959</u> to <u>2 MAY 59</u> and last saw her alive on <u>2 May 59</u> Death occurred at <u>9:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>JW Allen MD</u> (Degree or title)	
22b. ADDRESS <u>Carrollton Mo</u>		22c. DATE SIGNED <u>15 MAY 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 16, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairhaven Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Norborne, Mo.</u>
24. FUNERAL DIRECTOR <u>Deitch Funeral Home</u> ADDRESS <u>Norborne, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 16, 1959</u>	
26. REGISTRAR'S SIGNATURE <u>Eileen Penniston</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 *Ben W Gibson*

Licensed Embalmer No. *2961*
P. O. Address *Carrollton*

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.