

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018715  
STATE FILE NUMBER

FILED JUN 4 1959 Registration District No. 280 Primary Registration District No. Registrar's No. 84

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Platte</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Platte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Weston</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Weston</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Matthew's Nursing Home 2</b>		Length of stay in lb <b>2 year</b>	d. STREET ADDRESS (If outside, give location) <b>Year</b>

3. NAME OF DECEASED (Type or print) First <b>Isaac</b> Middle <b>S.</b> Last <b>Stephens</b>			4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1871</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	11. BIRTHPLACE (City and state or country) <b>Owingsville, Ky.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Thomas Stephens</b>	13b. MOTHER'S MAIDEN NAME <b>Juelda Gregory</b>	14. NAME OF HUSBAND OR WIFE <b>Maude Goodpaster</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>401-36-0419</b>	17. INFORMANT Address <b>Emery Stephens Weston, Missouri</b>
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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) <b>Gangrene left foot, beginning big toe</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis, Reynauds disease</b>		<b>10 years</b>
DUE TO (c) <b>Diabetes Mellitus</b>		<b>8 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>XXXXXXXXXX</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <b>XXXXXXX</b> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>XXXXXXXXXXXXX</b>
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ <b>XXXXXXXXXX</b>	<b>XXXXXXXXXXXXX</b>

20d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK OR NOT WHILE WORKING <input type="checkbox"/> AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) <b>XXXXXXXXXX</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Weston Platte Missouri</b>
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21. I attended the deceased from **Dec. 15, 1958** to **May, 20, 1959** and last saw him alive on **May, 19, 1959**  
Death occurred at \_\_\_\_\_ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Lewis C. Calvert M.D.</b> (Degree or title)	22b. ADDRESS <b>Weston Missouri</b>	22c. DATE SIGNED <b>5/22/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-22-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Ridge Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Weston, Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Vaughn funeral Home Weston, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>May 22, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Alphie Rollins.</b>
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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 W. R. Vaughn .....

Licensed Embalmer No. 4023

P. O. Address Weston, Ma

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.