

AMENDED

Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 179

1. PLACE OF DEATH a. COUNTY ST FRANCOIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST FRANCOIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FARMINGTON MO.		Length of stay in 1b	c. CITY OR TOWN FARMINGTON
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 629 WARREN ST
3. NAME OF DECEASED (Type or print) First DAISY Middle LOU Last STEVENSON		4. DATE OF DEATH Month MAY Day 7 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/17/79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 82
13a. FATHER'S NAME AMOS K STEVENSON		13b. MOTHER'S MAIDEN NAME JANE WALLACE	12. CITIZEN OF WHAT COUNTRY U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	14. NAME OF HUSBAND OR WIFE
17. INFORMANT CARL STEVENSON PEORIA ILL.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
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) Duodenal Ulcer			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 _____ a.m. _____ p.m.	Month, Day, Year _____		
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	COUNTY _____ STATE _____
21. I attended the deceased from 4-9-61 to 5-7-61 and last saw her <u>her</u> alive on 5-3-61 Death occurred at 6 AM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C.E. Carleton, M.D.		22b. ADDRESS Farmington, Mo	22c. DATE SIGNED 5-8-61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5/9/61	23c. NAME OF CEMETERY OR CREMATORY K OF P	23d. LOCATION (City, town, or county) (State) FARMINGTON MO.
24. FUNERAL DIRECTOR C.H.COZEAN FARMINGTON MO.		25. DATE RECD. BY LOCAL REG. May 8, 1961	26. REGISTRAR'S SIGNATURE Eather Rudloff

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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. H. Coogan

Licensed Embalmer No. _____

P. O. Address _____

0408
Farmington

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.