MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-029798

FILED AUG 23 1961

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 420 STATE FILE NUMBER

AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Independence Sanitarium + Hospital — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Independence — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 209 So Noland — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Baby Middle Last Stevens.

4. DATE OF DEATH Month July Day 31, Year 1961

5. SEX Male
6. COLOR OR RACE white
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH July 31, 1961
9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours 0 Min. 47

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Independence Mo
12. CITIZEN OF WHAT COUNTRY U S A

13a. FATHER'S NAME Cleo James Stevens.
13b. MOTHER'S MAIDEN NAME June Marie Hutson
14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT [illegible] Address [illegible]

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) Pulmonary atelectasis + fibrosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Imperforate anus Patent Ductus Ao
DUE TO (c) Interventricular Septal Defect
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) E K Dorsett
22b. ADDRESS Indep Mo
22c. DATE SIGNED 7-31-61

23a. ~~BURIAL~~ CREMATION, ~~REMOVAL~~ (Specify)
23b. DATE 7-31-61
23c. NAME OF CEMETERY OR CREMATORY Indep. San. + Hosp.
23d. LOCATION (City, town, or county) (State) Indep. Mo

24. FUNERAL DIRECTOR ADDRESS
25. DATE RECD. BY LOCAL REG. 7-31-61
26. REGISTRAR'S SIGNATURE Alba L. Craig

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

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.