

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-033910

STATE FILE NUMBER

AMENDED

Registration District No. 394 Primary Registration District No. _____ Registrar's No. 108

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Reynolds</u> | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Reynolds</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ellington</u> | | Length of stay in 1b <u>35 yrs</u> | c. CITY OR TOWN <u>Ellington</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Ellington</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Cecil</u> Middle <u>Lela</u> Last <u>Stogsdill</u> | | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>4</u> Year <u>1961</u> |
| 5. SEX <u>FEMALE</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>1-22-1897</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 9. AGE (last birthday) <u>64</u> IF UNDER 1 YEAR Months <u>8</u> Days <u>12</u> IF UNDER 24 HR Hours _____ Min. _____ |
| 11a. BIRTHPLACE (City and state or county) <u>Ashtown ARK</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Silas Fisse L</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARY ANN Edington</u> | 14. NAME OF HUSBAND OR WIFE <u>Jesse Stogsdill</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> | | 17. INFORMANT Address <u>Jesse Stogsdill Ellington 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>Carcinoma (Lymphoma?)</u> DUE TO (b) <u>Exploratory Surg. Failed To</u> DUE TO (c) <u>show PRIM. SITE.</u> 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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> |
| 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 _____ Month, Day, Year _____ | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>1950</u> to <u>Sept 4/61</u> and last saw her alive on <u>Sept 4/61</u> Death occurred at <u>3:45 P.m</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Kenneth T. Carter, M.D.</u> | | 22b. ADDRESS <u>Ellington Mo</u> | 22c. DATE SIGNED <u>Sept 11/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>9-7-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ellington Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Ellington Mo</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>McSpadden Funeral Home UAW Bldg</u> | | 25. DATE RECD. BY LOCAL REG. <u>SEPT-15-1961</u> | 26. REGISTRAR'S SIGNATURE <u>Elma Jarved</u> |

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. _____

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.