

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=61-035575**

STATE FILE NUMBER

AMENDED

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 188

FILED SEP 25 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b>		Length of stay in 1b <b>7 Hour</b>	c. CITY OR TOWN <b>Bertrand</b>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Delta Comm. Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>Route # 1</b>
3. NAME OF DECEASED (Type or print) First <b>AUDIE</b> Middle <b>LEE</b> Last <b>STEPHENSON</b>		4. DATE OF DEATH Month <b>9</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/8/1900</b>
9. AGE (last birthday) <b>61</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Poynor, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>James Stephenson</b>	
13b. MOTHER'S MAIDEN NAME <b>Melissa Scott</b>		14. NAME OF HUSBAND OR WIFE <b>Katie Schlachter</b>	
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.	
17. INFORMANT <b>Katie Schlachter Stephenson</b>		Address <b>Rt # 1 Bertrand, Mo.</b>	
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>ACUTE COR. ART. OCCLUSION</b> DUE TO (b) <b>ART. SCLER. HEART DIS.</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 a.m. p.m.			
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.) <b>1960</b>	20f. CITY, TOWN, OR LOCATION <b>9-14-61</b>	COUNTY STATE
21. I attended the deceased from <b>2:10 P.</b> to <b>9:14.61</b> and last saw her/him alive on <b>9.14.61</b> Death occurred at <b>2:10 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Carl G. Papp MD</b> (Degree or title)		22b. ADDRESS <b>Sikeston, Mo</b>	22c. DATE SIGNED <b>9.15.61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/17/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Armor</b>	23d. LOCATION (City, town, or county) (State) <b>Near Bertrand, Mo.</b>
24. FUNERAL DIRECTOR <b>Mc Mickle, Charleston, Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>9-22-61</b>	26. REGISTRAR'S SIGNATURE <b>Pro. One D. Hall Reg.</b>

**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 BRUCE R. AUSTIN, Student Embalmer No. 613

working under my personal supervision.

Student Bruce R. Austin Signed Elgin M. Minter  
Signature of Student Embalmer

Licensed Embalmer No. 4695

P. O. Address Charleston, TN

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.