

No. 300  
10.48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38414

State File No. ....

FILED NOV 17 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 298 PRIMARY REG. DIST. NO. 4448 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lawson</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lawson</u>	
c. LENGTH OF STAY (in this place) <u>27 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>0 990</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>BARBARA</u>	b. (Middle) <u>ALLEN</u>	c. (Last) <u>STOUT</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 9 54</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar 20 1883</u>	9. AGE (In years last birthday) <u>71</u>	10. MONTH <u>7</u>	11. DAY <u>19</u>	12. HOUR <u>1</u>	13. MINUTE <u>1</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Ray Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>Benjamin Riggs</u>	13b. MOTHER'S MAIDEN NAME <u>Armanda Fisher</u>	14. NAME OF HUSBAND OR WIFE <u>Wm. S. Stout</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Charles Stout</u>	ADDRESS <u>Lawson Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3-5 yrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Hemorrhage &amp; Cardiac Failure</u>		
	ANTECEDENT CAUSES <u>Duodenal Carcinoma</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>152X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>Lawson Ray Mo</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Nov 6, 1954, to Nov 9, 1954, that I last saw the deceased alive on Nov 9, 1954, and that death occurred at 7:15 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Robert Buehner M.D.</u>	23b. ADDRESS <u>Lawson Mo</u>	23c. DATE SIGNED <u>11/11/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 11 '54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Lawson Mo</u>
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DATE REC'D BY LOCAL REG. <u>Nov 11, 1954</u>	REGISTRAR'S SIGNATURE <u>Ms. Raymond Kline</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman Pritchard</u>	ADDRESS <u>Lawson Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 .....

Student Embalmer

Signed

*Luidee Jarman*

Licensed Embalmer No. *4589*

P. O. Address *Excelsior Springs Mo*

**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 this body is not embalmed, fact should be so stated above.