

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

17448

1. PLACE OF DEATH

County Callaway

Registration District No. 104

Township _____

Primary Registration District No. 3008

City Fulton (No. _____)

File No. _____

Registered No. 110

St. _____ Ward _____

2. FULL NAME

Charles William Stambaugh

(a) Residence. No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5/3 1870

7. AGE YEARS <u>59</u>	MONTHS <u>0</u>	DAYS <u>25</u>	IF LESS than 1 day, _____ hrs. or _____ min.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer 30

(b) General nature of industry, business, or establishment in which employed (or employer) 36

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Penn.
(STATE OR COUNTRY)

10. NAME OF FATHER Henry Stambaugh

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Penn.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Cathrine Barrick

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Penn.
(STATE OR COUNTRY)

14. INFORMANT H. Stambaugh
(Address) Fulton Mo.

15. FILE May 25 1929 R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/28 1929

17. I HEREBY CERTIFY, That I attended deceased from May 27 1929 to May 28 1929 that I last saw him alive on May 27 1929 and that death occurred, on the date stated above, at 5.30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

A General Septic infection from a probable tubercular condition of the urinary bladder.
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) H. P. Owen, M. D.

, 19 1929 (Address) Fulton Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hamesprarie Mo. DATE OF BURIAL 5/29 1929

20. UNDERTAKER Herndon Taylor ADDRESS Fulton Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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