

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

Do not use this space.

41122

**1. PLACE OF DEATH**

County Jasper  
Township Webb City  
City Webb City (In)

Registration District No. 417  
Primary Registration District No. 3021

File No. \_\_\_\_\_  
Registered No. 167  
St. \_\_\_\_\_ (Ward)

**2. FULL NAME**

Chas. Ernest Stalnaker  
(a) Residence. No. 1118 N. Broadway 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>Married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Alcie Stalnaker</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 11, 1867</u>					
7. AGE	YEARS <u>62</u>	MONTHS <u>4</u>	DAYS <u>X</u>	IF LESS than 1 day, _____ hrs. or _____ min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Music Operator</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer					

9. BIRTHPLACE (CITY OR TOWN) Alton  
(STATE OR COUNTRY) Ill.

PARENTS	10. NAME OF FATHER <u>Wm. L. Stalnaker</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>W. Va.</u>
	12. MAIDEN NAME OF MOTHER <u>Anna Brown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill.</u>

14. INFORMANT Mrs. Alcie Stalnaker  
(Address) Webb City, Mo.

15. FILED 12/13, 1929 R. M. Stormont  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 17 19 29  
17. HEREBY CERTIFY, That I attended deceased from April 1, 1929, to Dec 17, 1929 that I last saw him alive on Dec 17, 1929, and that death occurred, on the date stated above, at 11:10 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Carcinoma of Throat  
45 F  
44 (duration) 2 yrs. mos. ds.  
CONTRIBUTORY (SECONDARY)  
(duration) \_\_\_\_\_ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_  
WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) Mrs. Laurita K. ...  
12-13, 1929 (Address) Webb City, 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 Mount Hope Cem DATE OF BURIAL 12/14, 1929

20. UNDERTAKER Webb City Und Co Webb City  
ADDRESS \_\_\_\_\_

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.

49

16

