

155-0 SEP 23 1938

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

29051
Do not use this space.

1. PLACE OF DEATH

(a) County Lewis Registration District No. 380
(b) Township _____ Primary Registration District No. 4224 Registered No. 18
(c) City New Franklin, Mo. Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Stapleton 314

(a) Residence, No. New Franklin Mo. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE Negro. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mattie Stapleton
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10/14/1850
7. AGE YEARS 87 MONTHS 10 DAYS - IF LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation Life

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/14/38 1938
22. I HEREBY CERTIFY, That I attended deceased from 8-14, 1938, to 8-14, 1938.
I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

Pulmonary Haemorrhage Date of onset 8-14-38

Other contributory causes of importance: Myocarditis
Senility

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lewis Co. Mo.
13. NAME Franklin Stapleton
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
15. MAIDEN NAME Mrs. Hanson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

Name of operation _____ Date of _____
What test confirmed diagnosis? Blood in mouth Was there an autopsy? no

17. INFORMANT (ADDRESS) Sam Kingsburg
New Franklin Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Burial DATE 8/16/38
19. FUNERAL DIRECTOR (NAME) (ADDRESS) G. S. Munson
New Franklin Mo.
20. FILED 8-15- 1938 823 West
10th St. Local Registrar.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____ (Signed) G. S. Munson, M.D.
(Address) New Franklin, Mo.

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.

1381

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 9/7/38

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

Registered Apprentice No., working under my personal supervision.

Signed H. P. Hall
Licensed Embalmer No. 3515
P. O. Address New Franklin, Miss.

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

29051

Do not use this space.

1. PLACE OF DEATH

(a) County Howard Registration District No. 380
 (b) Township _____ Primary Registration District No. 4224 Registered No. 18
 (c) City New Franklin (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Stapleton

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 87 10 _____
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/14, 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h. _____ alive _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Pulmonary Hemorrhage
Rupture of aneurism of aorta. Date of onset _____

Other contributory causes of importance

Myo. Carditis
Senility

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____.

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) G. L. Chamberlain, M. D.

(Address) New Franklin Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

This statement of Occurrence is very important.

