DEC'D SEP 26 1938

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

30140
Do not use this space.

1. PLACE OF DEATH
(a) County SHELBY Registration District No. 830
(b) Township LENTNER Primary Registration District No. 6095 Registered No. 21
(c) City ..... (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 GEORGE WASHINGTON STALCUP 342
(a) Residence, No. ..... 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

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ SARAH ALICE STALCUP

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JAN. 24, 1863

7. AGE: YEARS 75 | MONTHS 1 | DAYS 4 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 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 .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) SHELBY COUNTY MISSOURI 0

FATHER
13. NAME JAMES THOMAS STALCUP 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) VIRGINIA 1

MOTHER
15. MAIDEN NAME MARY ANN BYARS
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) VIRGINIA

17. INFORMANT (ADDRESS) Elsie M Bryden 708 W 30 Okla City Okla

18. BURIAL, ~~CREMATION, OR REMOVAL~~ PLACE OAK RIDGE CEM. DATE AUG. 27, 1938

19. FUNERAL DIRECTOR (ADDRESS) E. Hayes Shelbina, Mo

20. FILED Sept 5, 1938 Ruth Joyner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-26-, 1938

22. I HEREBY CERTIFY, That I attended deceased from 3-4-34, 19..., to 8-20-38, 19...
I last saw him alive on 8-20-38, 19..... Death is said to have occurred on the date stated above, at 11 a. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Mitral regurgitation	3-4-34
Chronic nephritis	2-4-35

Other contributory causes of importance: Hypertension

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical Was there an autopsy? no

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) A. M. Wood, M. D.
749 (Address) Shelbina Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED
District Health Officer No. 10
District File Number 10-38-158
Date Filed 9-16-38

MAY 12 1957

STATEMENT BY LICENSED EMBALMER

I, E. Hayes, Licensed Embalmer No. 1437

hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed E. Hayes

Licensed Embalmer No. 1437

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
(a) County Shelby Registration District No. 830
(b) Township Lentfee Primary Registration District No. 6095 Registered No.
(c) City (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 George Washington Stalcup
(a) Residence, No. 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

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 24 1863

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	7	24	

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

MOTHER
15. MAIDEN NAME
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 Oct 8, 1938 Ruth Joyner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8 - 26 ,1938

22. I HEREBY CERTIFY, That I attended deceased from ,19 to ,19
I last saw h. 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:

	Date of onset
Other contributory causes of importance:	

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) A. M. Wood, M. D.
(Address) Shelbina Mo

SUPPLEMENTARY

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

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

Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. .....

(b) Township ..... Primary Registration District No. ..... Registered No. .....

(c) City ..... (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 .....

(a) Residence No. ..... St. ☐ If none, identify, give city or town and state

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) .....

S-30140

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as lawyer, bookkeeper, etc.

9. Industry or business in which work was done, as lawn 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)

13. NAME

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

15. MAIDEN NAME

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 ..

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) ..... 19 ..

22. I HEREBY CERTIFY, That I attended the deceased from ..... 19 ..

I last saw ..... alive on ..... 19 ..

to have occurred on the date stated above, at ..... m.

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

Date of death

Other contributing causes of importance:

Name of operation ..... Date of ..... 19 ..

What test was used to confirm diagnosis? ..... Was diagnosis confirmed by ..... 19 ..

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

Accident, suicide, or homicide ..... Date of injury ..... 19 ..

Was injury due to injury occurred ..... Specify city or town 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?

Filed ..... 19 ..

Address ..... 19 ..