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.

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

41116
Do not use this space.

2

1. PLACE OF DEATH
(a) County Worth
(b) Township Fletchall
(c) City Grant City, Mo (d) Street No. .... St.
Registration District No. 988
Primary Registration District No. 4
Registered No. ....
(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 CALVIN STARK
(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): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Elizabeth Stark
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Dec. 17, 1856
7. AGE: YEARS 82, MONTHS 9, DAYS 22. If LESS than 1 day, ... hrs. or .... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Retired Grocerym
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) Versailles
(STATE OR COUNTRY) Indiana

FATHER
13. NAME Elijah Stark
14. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Kentucky

MOTHER
15. MAIDEN NAME Elizabeth Johnson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Charley Stark
(ADDRESS) Grant City, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Grant City Cem. DATE 10/11 1939

19. FUNERAL DIRECTOR (NAME) Arch C. Dunfee
(ADDRESS) Grant City, Mo.

20. FILED 12/9 1939 Fred Mull M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 9, 1939

22. I HEREBY CERTIFY, That I attended deceased from June, 1937, to Oct. 9, 1939

I last saw him alive on Oct. 9, 1939. Death is said to have occurred on the date stated above, at 7:10 a.m.

The principal cause of death and related causes of importance were as follows: Mitral regurgitation — Date of onset 1930

92 H

Other contributory causes of importance: Hypertension

Name of operation .... Date of ....
What test confirmed diagnosis? Physical findings. 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) [illegible] M. D.
(Address) Grant City, Mo

Licensed Embalmer's Statement on Reverse Side)

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, ... Arch C Dunfee ...., or by .... Registered Apprentice No........................, working under my personal supervision.

Signed Arch C Dunfee

Licensed Embalmer No. 3252

P. O. Address Grant City, Mo

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

If this body is not embalmed, above space should be left blank.