

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

42991
Do not use this space.

1. PLACE OF DEATH

(a) County Carrroll Registration District No. 135
 (b) Township Carrallton Primary Registration District No. 3010 Registered No. 149
 or City Carrallton (d) Street No. South Side Hospital
 (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 Mr. Andrew B. Stamper

(a) Residence, No. Waverly road St. Waverly, Mo.
 (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 Zella Stamper

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 5, 1897

| | | | | |
|--------|-----------|----------|-----------|----------------------------------|
| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
| | <u>62</u> | <u>9</u> | <u>17</u> | |

OCCUPATION

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

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) Morgan County, Ky.

FATHER

13. NAME John G. Stamper

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

MOTHER

15. MAIDEN NAME Nancy Barnes

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.

17. INFORMANT (ADDRESS) Lee Stamper
Cleveland, Ohio

18. BURIAL, CREMATION, OR REMOVAL
PLACE Waverly, Mo. DATE Dec. 24, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. J. James
Concordia, Mo.

20. FILED 12/22 1939 Walter Hasbun
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1939, to Dec 22, 1939.
 I last saw him alive on Dec 22, 1939. Death is said to have occurred on the date stated above, at 11:20 A.
 The principal cause of death and related causes of importance were as follows:
Mitral stenosis
Systematic nephritis
Bergian disease
Gonorrhea left foot and leg

Date of onset

Other contributory causes of importance:
121

Name of operation Augustine Mill High Date of operation Dec 21, 39
 What test confirmed diagnosis? Gonorrhea 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) J. M. Deussen, M. D.
 (Address) Canton, 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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MAY 2 1947

RECEIVED
District Health Officer No. 8,
District File Number 119740
Date Filed

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.....

Robert L. Painter....., Registered Apprentice No.....
working under my personal supervision.

Signed *Robert L. Painter*
Licensed Embalmer No. *4069*
P. O. Address *Concordia, Mo.*

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.