5
4
6

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.

FEB MAR 16 1940

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

6790
Do not use this space.

1. PLACE OF DEATH

(a) County Howard Registration District No. 379

(b) Township Chariton 2 Primary Registration District No. 4223 Registered No.

(c) City Glasgow 0 (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 68 yrs. — mos. 13 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 314 ELIZABETH WELLS STAPLETON

(a) Residence, No. Glasgow 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

3. SEX: Female
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 1, 1872

7. AGE: YEARS 68 | MONTHS — | DAYS 13 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc. Homes
10. Date deceased last worked at this occupation (month and year) Feb. 13, 1940
11. Total time (years) spent in this occupation 56

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howard County Mo

FATHER
13. NAME Robinson Wells
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia 1

MOTHER
15. MAIDEN NAME Millie Robinson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri 0

17. INFORMANT (ADDRESS) John Stapleton Glasgow Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Glasgow Mo. DATE Feb. 16 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Walker Audsley Glasgow Mo.

20. FILED 2-15 1940 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 13 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1940, to Feb 13, 1940
I last saw her alive on Feb 13 1940 Death is said to have occurred on the date stated above, at 4:30 P m.
The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage — Date of onset 2-13-40

82 hr

Other contributory causes of importance:

Name of operation None 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) [signature], M. D.
(Address) Glasgow Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
File Number
Date Filed 3-11-40

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, J. Walker Audsley, or by .....

Registered Apprentice No. ....., working under my personal supervision.

Signed J. Walker Audsley

Licensed Embalmer No. 3336

P. O. Address Glasgow 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.