

JUN 15 1940

State File No. _____

Registration District No. 385

Primary Registration District No. 5537

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Trask, Howell County, Mo.
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days 4 yrs 3 1/4

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell
(c) City or town Trask
(If outside city or town limit write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME William Henry Stapleton.

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bertha A. Stapleton. 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased Nov. 6th. 1858
(Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Sandwidge, Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Merchant

11. Industry or business General Merchandise

12. Name Tom Stapleton.

13. Birthplace Dont Know 9
(City, town, or county) (State or foreign country)

14. Maiden name Mary 5

15. Birthplace IRLAND Irland
(City, town, or county) (State or foreign country)

16. (a) Informant Cirero H. Stapleton
(b) Address Mountain View, Mo

17. (a) _____ (b) Date thereof 5-10-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walkers Chapel
18. (a) Signature of funeral director _____
(b) Address Willow Springs, Mo.
19. (a) 5-10-40 (b) Manette Ferguson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 7
year 1940 hour 10 minute 20 P.M.

21. I hereby certify that I attended the deceased from 5-5-40
_____ 19____, to 5-7-1940
that I last saw him alive on 5-7-1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 2 yrs
Due to _____
Due to 920
Hypertrophic Prostatitis 1936
Bronchial Asthma 1920
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
345
(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature Dr. Callahan (M. D. or other) 1
Address Willow Springs, Mo Date signed 5-8-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Thomas R. Burns, Jr

Registered Apprentice No. 251

working under my personal supervision.

RECEIVED

Signed.....

T. R. Burns, Jr.

District Health Officer No. 5

Licensed Embalmer No. 1847

District File Number 640 668

P. O. Address Willow Springs. Mo.

Date Filled 6.12.40

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.