

FILED SEP 6 1941  
Registration District No. 566

Primary Registration District No. 3130

1. PLACE OF DEATH:

(a) County **Mississippi**  
(b) City or town **Charleston,**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**511 West Cleveland Street /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **30 years**  
(Specify whether years, months or days)  
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Mississippi**  
(c) City or town **Charleston,**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **511 West Cleveland Street**  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) **(Yes)**  
If yes, name country

3. (a) PRINT FULL NAME **Dora Stella Stubblefield**

3. (b) If veteran, name war **X X X** 3. (c) Social Security No. **X X X**

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

6. (b) Name of husband or wife **Russell Stubblefield** 6. (c) Age of husband or wife if alive **49** years

7. Birth date of deceased **January 14 1883**  
(Month) (Day) (Year)

8. AGE: Years **58** Months **7** Days **10** If less than one day hr. min.

9. Birthplace **Shawnee town Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**  
**At home**

11. Industry or business

12. Name **T.H. Miller**

13. Birthplace **Smithland Kentucky**  
(City, town, or county) (State or foreign country)

14. Maiden name **Martha York**

15. Birthplace **Unknown Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Russell Stubblefield**

(b) Address **Charleston, Missouri**

17. (a) **Burial** (b) Date thereof **8-25-41**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove-Charleston**

18. (a) Signature of funeral director **Lair-Nunnelee**

(b) Address **Charleston, Missouri**

19. (a) **8-27-41** (b) **F. S. Vernon**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **24th.**  
year **1941** hour **8** minute **30** A.M.

21. I hereby certify that I attended the deceased from **April 8**, 1940, to **Aug 25**, 1941;  
that I last saw him alive on **Aug 24**, 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Carcinoma of Cervix Uteri**  
Due to **with generalized carcinomatosis**

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature **Willis L. Davis** (M. D. or other) **MD**  
Address **Charleston, Mo** Date signed **8-27-41**

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

RECEIVED

District Health Office No. 2,

District File Number 941-1214

Date Filed 9/4/41

8

**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.....

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

*Not Embalmed*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

**If this body is not embalmed, fact should be so stated above.**