

Registration District No. **1001**

Primary Registration District No. **1001**

Registrar's No. **1073**

1. PLACE OF DEATH:  
 (a) County **BUCHANAN**  
 (b) City or town **ST. JOSEPH**  
 (c) Name of hospital or institution: **STATE HOSPITAL No. 2**  
 (d) Length of stay: In hospital or institution **1 1/4 years**  
 In this community **yes**

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Clay**  
 (c) City or town **Rural**  
 (d) Street No. **0**  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Lucinda Stalling**  
 3. (b) If veteran, name war **/**  
 3. (c) Social Security No. **mm**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **October** day **21**  
 year **1941** hour **12:10** minute \_\_\_\_\_ A. M.  
 21. I hereby certify that I attended the deceased from **Oct 6**  
 to **Oct 21**, 19**41**  
 that I last saw her alive on **Oct 21**, 19**41**  
 and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **White**  
 6. (b) Name of husband or wife **John Stalling**  
 6. (c) Age of husband or wife if alive **unk** years

Immediate cause of death **Respiratory pneumonia**  
**unresolved arteriosclerotic**  
**Heart disease (Aneurysm)**  
 Duration \_\_\_\_\_

8. AGE: **75** Years  
 Months **?** Days **?**  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) **10-1**

9. Birthplace **Clay Co. Mo**  
 10. Usual occupation **Housewife**

Major findings:  
 Of operations **/**  
 Of autopsy **/**  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
 12. Name **unk**  
 13. Birthplace **unk**  
 14. Maiden name **unk**  
 15. Birthplace **unk**

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? \_\_\_\_\_  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? **/**

16. (a) Informant **State Health #2**  
 (b) Address **St Joseph Mo**  
 17. (a) **Removal** (b) Date thereof **Oct 25 1941**  
 (c) Place: burial or cremation **Liberty, Mo - James**  
 18. (a) Signature of funeral director **Liberty, Mo**  
 (b) Address **Liberty, Mo**  
 19. (a) **Oct 27, 1941** (b) **H. J. Mustabush**  
 (Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
 23. Signature **R. B. Dineary** (M. D. or other) **M. D.**  
 Address **State Hospital #2 St Joseph** Date signed **10/22/41**

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

MOTHER FATHER

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**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.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**