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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1945
Registration District No. 294

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3164
Registrar's No. 21

Primary Registration District No. 3056

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

1. PLACE OF DEATH:
(a) County RANDOLPH
(b) City or town MOBERLY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
WOODLAND
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month
In this community ALL HIS LIFE / (Specify whether years, months or days)

3. (a) PRINT FULL NAME JAMES THOMAS STALEUP
3. (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 ELLA / 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased MARCH-11th (Month) (Day) (Year) 1889

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>10</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace SHELBY CO MO (City, town, or county) (State or foreign country)
10. Usual occupation STANDARD OIL BULK STATION
11. Industry or business _____

MOTHER, FATHER {
12. Name WILLIAM STALEUP
13. Birthplace MISSOURI (City, town, or county) (State or foreign country)
14. Maiden name JENNIE PHILLIPS
15. Birthplace SHELBY MISSOURI (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ella Staleup
(b) Address Clarence Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 31-1945 (Month) (Day) (Year)
(c) Place: burial or cremation BURIAL Clarence Mo

18. (a) Signature of funeral director William P. Boshelaw
(b) Address Clarence Mo.

19. (a) 2-5-45 (Date received local registrar) (b) Anna Hale (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County SHELBY / 02
(c) City or town CLARENCE / 10
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? N. / (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month JAN day 29 year 1945 hour 5:35 minute AM
21. I hereby certify that I attended the deceased from JAN 5 1945 to JAN 29 1945 and that I last saw him alive on JAN 29 1945 and that death occurred on the date and hour stated above

Immediate cause of death Coronary Occlusion / Sudden
Due to Bright Disease / 1 mo
Due to Non-specific lung infection / 1 mo
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 Anna Hale (M. D. or other) _____
Address _____ Date signed 3/2/45

JUN 20 1945

RECEIVED
District Health Officer, No. 10
District File Number 2-45-325
Date Filed FEB 11 1945

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 Dwight A. Barkeley

Licensed Embalmer No. 3835

P. O. Address Stellman - 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME

James J. Stalcup

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased march 11

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

56

min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____

(Date received local registrar)

(b) _____

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 9
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to - acute 130

Due to - Respiratory infection

Other conditions (Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations _____

Of autopsy _____

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 Thos. S. Fleming, M.D. (M. D. or other) _____
Address _____ Date signed 2/15/45

Moberly, Missouri

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

SUPPLEMENTARY

3164