

No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED APR 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7875

BIRTH NO. _____ REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 4154 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY Dade		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Dade	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Greenfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Greenfield	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) College St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home			

3. NAME OF DECEASED (Type or Print) a. (First) Lucinda	b. (Middle)	c. (Last) Stapp	4. DATE OF DEATH (Month) (Day) (Year) Mar 28, 1949
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept 18, 1861	9. AGE (In years last birthday) 87	10. UNDER 1 YEAR Days 8	11. UNDER 1 YEAR Hours 10	12. UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) Mo. U		12. CITIZEN OF WHAT COUNTRY? U.S.A	

13a. FATHER'S NAME ED Bowels	13b. MOTHER'S MAIDEN NAME Katherin Bowels	14. NAME OF HUSBAND OR WIFE Aquilla Stapp
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Horace Stapp	ADDRESS Greenfield, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Sanctity</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		794X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title)	23b. ADDRESS <i>Greenfield</i>	23c. DATE SIGNED 3-30-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar 31, 1949	24c. NAME OF CEMETERY OR CREMATORY Pennsboro Cemetery	24d. LOCATION (City, town, or county) (State) Pennsboro Mo.
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DATE REC'D BY LOCAL REG. 2-30-49	REGISTRAR'S SIGNATURE <i>[Signature]</i>	790	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS Greenfield, Mo.
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RECEIVED

District Health Officer No. 6,

District File Number 449-379

Date Filed 4-6-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W.R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield, 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: