

FILED JUN 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15582

No. 300

10.48

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129
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BIRTH NO.		REG. DIST. NO. 128	PRIMARY REG. DIST. NO. 2000	Registrar's No. 501
1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene 29		
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Springfield 2		
c. LENGTH OF STAY (in this place) 48 Yrs		d. STREET ADDRESS (If rural, give location) 1043 College 1 6		
d. FULL NAME OF HOSPITAL OR INSTITUTION		4. DATE OF DEATH (Month) (Day) (Year) June 5, 1949		
3. NAME OF DECEASED (Type or Print) a. (First) William	b. (Middle)	c. (Last) Stark	5. SEX Male 6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 9, 1874		9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF OVER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer	10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Lanesville, Indiana 1		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Della Stark		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. ?	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Della Stark Springfield, Mo.		
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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombosis, Coronary ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial Ch. De-compensation DUE TO (c) Arterio-sclerosis		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 6 Months (4 30)	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from April , 1949, to 5 June , 1949, that I last saw the deceased alive on 4 June , 1949, and that death occurred at 2:30 m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) J. Newton Wakeman M.D.		23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 6/6/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/7/49	24c. NAME OF CEMETERY OR CREMATORY Hazelwood	24d. LOCATION (City, town, or county) (State) Springfield, Mo.	
DATE REC'D BY LOCAL REG. 6/6/49	REGISTRAR'S SIGNATURE W.E. Handley M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H.H. Johnson Springfield, Mo.		

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.

Signed _____

Walter E. Dumont

Signed _____
Student Embalmer

Licensed Embalmer No. *3808*

P. O. Address *Springfield 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.