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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7994

No. 300
10. 48

State File No.

FILED MAR 31 1952

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 312

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

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>	
c. LENGTH OF STAY (In this place) <u>2 weeks</u>		d. STREET ADDRESS (If rural, give location) <u>313 North Lexington</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Baptist Hospital</u>			

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3. NAME OF DECEASED (Type or Print) a. (First) <u>RETA</u> b. (Middle) <u>STALLINGS</u> c. (Last) <u>CORING</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 27 1952</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 17, 1873</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Conway, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>John Stallings</u>	13b. MOTHER'S MAIDEN NAME <u>Corilla Roberson</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John L. Coring, Springfield, Missouri</u>	ADDRESS _____
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>8</u> <u>584X</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Adeno Carcinoma of Liver & gall bladder</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Cholelithal Gallstones</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>3-7-52</u>	19b. MAJOR FINDINGS OF OPERATION <u>Cholelithal Gallstone gangrenous gall bladder</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 2-27, 1952, to 3-27, 1952, that I last saw the deceased alive on 3-27, 1952, and that death occurred at 8:10P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>C. E. Feller</u>	23b. ADDRESS <u>609 Cherry Springfield</u>	23c. DATE SIGNED <u>3-28-52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>March 31, 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>3-29-52</u>	REGISTRAR'S SIGNATURE <u>JAMES H. AMOS, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Alma Schmeiser, Springfield, Mo</u>	ADDRESS <u>3W</u>
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed

James W. Wair

Signed.....
Student Embalmer

Licensed Embalmer No. *4650*

P. O. Address *Springfield, Mass*

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.