

FILED JUN 1 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15688

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>82</u>			
1. PLACE OF DEATH a. COUNTY Howell				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Howell					
b. CITY (If outside corporate limits, write RURAL and give town) West Plains,		c. LENGTH OF STAY (In this place) 20 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) West Plains,		0461			
d. FULL NAME OF HOSPITAL OR INSTITUTION X				d. STREET ADDRESS (If rural, give location) SOUTH SUBURBS					
3. NAME OF DECEASED (Type or Print) ELBERT CLAY STINNETT			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH 5-12-54		(Month)		(Day)		(Year)			
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M		8. DATE OF BIRTH 11-25-1884		9. AGE (In years last birthday) 69	
IF UNDER 1 YEAR Months 5 Days 7		IF UNDER 24 HRS. Hours 1 Min. 0		11. BIRTHPLACE (State or foreign country) MTN. HOME, ARKANSAS		12. CITIZEN OF WHAT COUNTRY? U S A			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER			10b. KIND OF BUSINESS OR INDUSTRY X			13a. FATHER'S NAME WILEY STINNETT		13b. MOTHER'S MAIDEN NAME REBECCA GOODALL	
14. NAME OF HUSBAND OR WIFE ARTIE STINNETT			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) X			16. SOCIAL SECURITY NO. 430-26-1038		17. INFORMANT'S SIGNATURE OR NAME ADDRESS ARTIE STINNETT, WEST PLAINS, 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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL INFARCTION				INTERVAL BETWEEN ONSET AND DEATH 15 MIN	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				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. Duodenal Ulcer								3 YEARS	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION. 4201						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) m.		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 APR 2, 1953 , to 5/12, 1954 , that I last saw the deceased alive on 1-29, 1954 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Joseph Wiles, M.D.				23b. ADDRESS West Plains, Mo		23c. DATE SIGNED 5-21-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) R		24b. DATE 5-14-54		24c. NAME OF CEMETERY OR CREMATORY Mtn. Home,		24d. LOCATION (City, town, or county) (State) Mtn. Home, Arkansas			
DATE REC'D BY LOCAL REG. 5-26-54		REGISTRAR'S SIGNATURE Beatrice Cook		25. FUNERAL DIRECTOR'S SIGNATURE Robertsons, West Plains, Mo		ADDRESS			

(Licensed Embalmer's Statement on Reverse Side)

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

p. 300
0.48

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

J. S. Roberts

Licensed Embalmer No. *3477*

P. O. Address *West Hill*

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.