

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37716

STATE FILE NUMBER

FILED NOV 19 1956

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1016-C

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Prairie Village		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Davis Nursing Home			Length of stay in 1b 3 Days		d. STREET ADDRESS (If outside, give location) 4116 W. 68th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LILLIAN F. STIFFLER				4. DATE OF DEATH Nov. 6, 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 20, 1870		9. AGE (In years last birthday) 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (City and state or country) Nixa, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alex West				14. MOTHER'S MAIDEN NAME Sarah Jane Payne			
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. None		17. INFORMANT Mrs. Harry D. Williams			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia							INTERVAL BETWEEN ONSET AND DEATH sev. days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) cerebral apoplexy							weeks
DUE TO (c) right hemiplegia							334 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 11-3-56 to 11-6-56 and last saw her/him alive on 11-5-56 Death occurred at 3:40 a. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) H. Williams M.D.				22b. ADDRESS Springfield, Mo.		22c. DATE SIGNED 11-9-56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/7/1956	23c. NAME OF CEMETERY OR CREMATORY Payne Cemetery		23d. LOCATION (City, town, or county) (State) Nixa, Missouri		
24. FUNERAL DIRECTOR J. Alan Harris		ADDRESS Clever, Mo.		25. DATE RECD. BY LOCAL REG. 11-14-56		26. REGISTRAR'S SIGNATURE Edith Williams	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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1-56

200
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1913

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.....
Signature of Student Embalmer

Signed.....
John Harris

Licensed Embalmer No. *439*

P. O. Address..... *Cleary*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.