

1. Health,  
& Welfare  
2. Public  
3. Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-043152  
STATE FILE NUMBER

FILED DEC 19 1958

Registration District No. 002 Primary Registration District No. 5079 Registrar's No. 68

5. 300  
v. 1-574

1. PLACE OF DEATH a. COUNTY <b>Andrew</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Andrew</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rochester</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Savannah 1020</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Shady Lawn Rest Home</b>		Length of stay in lb <b>8 1/2 months</b>	d. STREET ADDRESS (If outside, give location) <b>6 mi N.W. of Savannah</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>-</b> Last <b>STAGGS</b>			4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>1958</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 4, 1875</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (City and state or country) <b>Park County, Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13a. FATHER'S NAME <b>Abraham Stagg</b>		13b. MOTHER'S MAIDEN NAME <b>Rachel Allgood</b>	
14. NAME OF HUSBAND OR WIFE <b>NORA STAGGS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Floyd Stagg</b>		Address <b>Rosendale Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hypostatic pneumonia</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>heart disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>					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 <b>8:00 A.</b> Month <b>6-9-58</b> Day <b>12</b> Year <b>1958</b>		20d. INJURY OCCURRED WHILE AT <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.) <b>6-9-58 to 12-13-58</b>		20f. CITY, TOWN, OR LOCATION <b>Savannah, Mo.</b>		COUNTY <b>Andrew</b> STATE <b>Mo.</b>	
21. I attended the deceased from Death occurred at <b>8:00 A.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					and last saw him alive on <b>12-13-58</b>
22a. SIGNATURE (Degree or title) <b>Walter C. Baker M.D.</b>			22b. ADDRESS <b>Savannah, Mo.</b>		22c. DATE SIGNED <b>12-15-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 15, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fillmore Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fillmore Mo.</b>
24. FUNERAL DIRECTOR <b>W. A. Rich</b>		ADDRESS <b>Savannah Mo</b>		25. DATE RECD. BY LOCAL REG. <b>12-15-58</b>	26. REGISTRAR'S SIGNATURE <b>Lillian Sparks</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Wm A Rich* .....

Licensed Embalmer No. *4778* .....

P. O. Address *Savannah, Ga* .....

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.