

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001061

STATE FILE NUMBER*

FILED JAN 26 1959 Registration District No. 128 Primary Registration District No. _____ Registrar's No. 54C

S. 300
1-57

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, give TOWNSHIP only) OR TOWN <u>N. Campbell townshp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Galloway</u> <u>6390</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sunshine Acres</u> Length of stay in 1b <u>2 1/2 yrs.</u>		d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>Clyde U. Stark</u>			4. DATE OF DEATH Month Day Year <u>Jan. 14, 1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>3</u> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	9. AGE (In years last birthday) <u>74</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11a. FATHER'S NAME <u>Samuel A. Stark</u>		11b. MOTHER'S MAIDEN NAME <u>Elizabeth Pullim</u>	14. NAME OF HUSBAND OR WIFE -----
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT (<u>Do.</u>) Address <u>Mrs. Kenneth Colorth-Springfield, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO (b) <u>Chronic Arthritis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH _____
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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>Jan. 1958</u> to <u>Death</u> and last saw ^{him} alive on <u>Jan 10, 1959</u> Death occurred at <u>5:00 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deduce or title) <u>Lyman W. Brown M.D.</u>		22b. ADDRESS <u>311 1/2 College</u>	22c. DATE SIGNED <u>1/16/59</u>
23a. BURIAL, CREMATION, REMOVAL-(Specify) <u>Burial</u>	23b. DATE <u>1-18, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Galloway Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Galloway, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Rea Rainey--Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-19-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

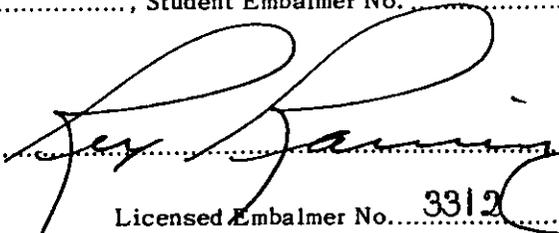
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

0912 4 1981

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  -----
Licensed Embalmer No. 3312
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.