

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012430

STATE FILE NUMBER

471

FILED MAY 11 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No.

300  
1-57

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Buchanan</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Missouri</b> b. COUNTY<br><b>Buchanan</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN<br><b>St. Joseph</b>                   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN<br><b>St. Joseph</b>                                       |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>1507 Highland Ave.</b> |  | Length of stay in 1b<br><b>32 years</b>   | d. STREET ADDRESS (If outside, give location)<br><b>1507 Highland Ave.</b> |
| Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                       |  |   |  |

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|---|--|--|----------------------|--|--|----------------------------|--|--|---|--|--|-----------------|--|--|---------------------|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>MAGGIE</b> |  |  | Middle<br><b>MAY</b> |  |  | Last<br><b>STALLSWORTH</b> |  |  | 4. DATE OF DEATH<br>Month<br><b>May</b> |  |  | Day<br><b>4</b> |  |  | Year<br><b>1959</b> |  |  |
|---|--|--|----------------------|--|--|----------------------------|--|--|---|--|--|-----------------|--|--|---------------------|--|--|

|                         |  |                                  |  |   |  |  |  |  |  |                           |  |                          |  |       |  |      |  |
|-------------------------|--|----------------------------------|--|---|--|--|--|--|--|---------------------------|--|--------------------------|--|-------|--|------|--|
| 5. SEX<br><b>Female</b> |  | 6. COLOR OR RACE<br><b>White</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 5, 1877</b> |  | 9. AGE (In years last birthday)<br><b>82</b> |  | IF UNDER 1 YEAR<br>Months |  | IF UNDER 24 HRS.<br>Days |  | Hours |  | Min. |  |
|-------------------------|--|----------------------------------|--|---|--|--|--|--|--|---------------------------|--|--------------------------|--|-------|--|------|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At home</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |  | 11. BIRTHPLACE (City and state or country)<br><b>Cainsville Missouri</b> |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b> |  |  |  |
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| 13a. FATHER'S NAME<br><b>William Stallsworth</b> |  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Adeline Holland</b> |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Henry Stallsworth (Deceased)</b> |  |  |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |  | 16. SOCIAL SECURITY NO. |  | 17. INFORMANT<br><b>Mrs. Ruie Oder</b> |  | Address <b>1507 Highland Ave St. Joseph, Mo.</b> |  |  |  |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>General Carcinomatosis</b> |  |  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unk.</b> |  |  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Carcinoma of the Cervix</b>                         |  |  |  |  |  |  |  |  |  | <b>Unk.</b>                                     |  |  |  |
| DUE TO (c)   |  |  |  |  |  |  |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)                              |  |  |  |  |  |  |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b> |  |

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| 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.)<br><b>171X</b> |  |  |  |  |  |  |  |  |
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| 20c. TIME OF INJURY<br>Hour<br>Month, Day, Year<br>a.m.<br>p.m. |  |  |  |  |  |  |  |  |  |  |  |
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| 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<br>COUNTY<br>STATE |  |  |
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| 21. I attended the deceased from <b>3/14/58</b> to <b>5/4/59</b> and last saw <del>her</del> <sup>her</sup> alive on <b>5/3/59</b><br>Death occurred at <b>7:25A</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |  |  |  |  |  |  |  |  |  |  |
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| 22a. SIGNATURE (Degree or title)<br><b>S. E. Melvinney M.D.</b> |  |  | 22b. ADDRESS<br><b>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</b> |  |  | 22c. DATE SIGNED<br><b>5/5/59</b> |  |  |
|---|--|--|---|--|--|-----------------------------------|--|--|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 23b. DATE<br><b>5-7-59</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Antioch Cemetery</b> |  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Gower Missouri</b> |  |  |
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| 24. FUNERAL DIRECTOR<br><b>Stoney Funeral Home</b><br>ADDRESS<br><b>St. Joseph, Mo.</b> |  |  |  | 25. DATE RECD. BY LOCAL REG.<br><b>May 7, 1959</b> |  | 26. REGISTRAR'S SIGNATURE<br><b>Wm Clark Woodell</b> |  |  |  |
|---|--|--|--|--|--|--|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.  
 Doctor, Coroner, etc. must use only standard nomenclature in Part I - no symptoms will be stated.  
 Dr. S. E. Melvinney  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Charles E. Bennett* .....

Licensed Embalmer No. *1677* .....

P. O. Address *St. Joseph, 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.