

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001389

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3550 Registrar's No. 16

FILED JAN 28 1963

DO NOT WRITE ON THIS STUB	AMENDED				
VS 300 Rev. 4/59	DATE AMENDED				
1 0460					
2 0460					
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12 90-0					
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF				
USE BLACK INK OR TYPEWRITER RIBBON	DOCUMENT				
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	MEDICAL CERTIFICATION				
SHOULD READ	BY AFFIDAVIT OF				
ITEM NO.					

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Moody</u>		Length of stay in 1b <u>since 5-1938</u>	c. CITY OR TOWN <u>Moody</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.F.D.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.F.D.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lillie Kay</u> Middle <u>Stapleton</u> Last <u>Stapleton</u>			4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1963</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	9. AGE (last birthday) <u>78 yrs.</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>South Fork, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Carroll</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Cox</u>	
14. NAME OF HUSBAND OR WIFE <u>Walter N. Stapleton</u>		17. INFORMANT Address <u>Walter Stapleton, Moody, Mo.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no; or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Necropsy</u> <u>Ac. Pulmonary Edema, Hypertension</u> <u>Atherosclerosis and Vasculitis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 _____ a.m. _____ p.m.	Month, Day, Year _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>22-4-61</u> to <u>21-1-63</u> and last saw her alive on <u>21-6-63</u> Death occurred at <u>2030 hours</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>West Plains, Missouri</u>	22c. DATE SIGNED <u>24/1/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1-24-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>South Fork, Mo</u>
24. FUNERAL DIRECTOR <u>Robertsons, West Plains, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-25-63</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

Smith

JAN 29 1966

**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. 3432

P. O. Address West Plains, 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.