

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 135

Primary Registration District No. 3010

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Cummins
(c) Name of hospital or institution: South Side Hospital
(d) Length of stay: In hospital or institution 2 wks.
In this community _____ years, months or days

8. (a) PRINT FULL NAME OLIVER ROSS STIFFE #310

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lydia Stiffey 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Aug 25 1866
(Month) (Day) (Year)

8. AGE: Years 73 Months _____ Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Penn. Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____
MOTHER FATHER { 12. Name John Stiffey
13. Birthplace Penn. Penn.
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Perent
15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Miss Lydia Stiffey
(b) Address Wale Mo.

17. (a) Chapel Hill Del. (b) Date thereof Sept. 27 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____
18. (a) Signature of funeral director Frank Slater
(b) Address Wale Mo.

19. (a) 9-20-39 (b) With Hasbain
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carroll
(c) City or town Boale Mo.
(d) Street No. _____
(e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 20
year 1939 hour 8 minute 30 A. M.

21. I hereby certify that I attended the deceased from Sept 12 39
Sept 20, 1939, to _____, 19____;
that I last saw him alive on Sept 20, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Shelton Paralysis -
arteriosclerosis -
Due to Chronic interstitial nephritis

Due to _____
Other conditions JHW
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature R M. ... (M. D. or other) _____
Address ... Date signed 9-20-39

RECEIVED FILED STATE OFFICE
INDEX CARD RETURNED TO DISTRICT
DATE 10/11/10

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carroll, 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 this body is not embalmed, above space should be left blank.