

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

42964

State File No. \_\_\_\_\_

Registration District No. 125

Primary Registration District No. 3009

Registrar's No. 425

1. PLACE OF DEATH:  
(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Mem. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 66 years years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Scott  
(c) City or town Rocky Hill, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. Madys St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME William T. Stobblefield  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 22  
year 1939 hour 1:50 minute 17 M.  
21. I hereby certify that I attended the deceased from Dec. 12, 1939, to Dec. 22, 1939  
that I last saw him alive on 12-22, 1939  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Roan Stobblefield 6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased Sept, 15 1873  
(Month) (Day) (Year)

Immediate cause of death Carcinoma, Cecum Duration 1 year.  
Due to \_\_\_\_\_  
Due to Hb

8. AGE: Years 66 Months 3 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Cornucopia, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business 0

MOTHER { 12. Name Maest Stobblefield  
13. Birthplace Nashville, Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Leckman  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Carcinoma, Cecum  
Of operations \_\_\_\_\_  
Of autopsy None.  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature J. P. Smith  
(b) Address Rocky Hill, Mo.

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? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

17. (a) Burial (b) Date thereof Dec 23-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rocky Hill, Mo.

18. (a) Signature of funeral director Edwin Ellis  
(b) Address Rocky Hill, Mo.

While at work? No. (Specify type of place) (e) Means of injury \_\_\_\_\_

19. (a) 12-22-39 (b) J.M. Thompson  
(Date received local registrar) (Registrar's signature)

23. Signature Frank W. Hall, M.D. (M.D. brother)  
Address Cape Girardeau, Mo. Date signed 12-24

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.

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, on Dec, 22

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

Signed

*Arthur Ellie*

Licensed Embalmer No.

3869

P. O. Address

*1115 1st St N*

**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.**