

1. PLACE OF DEATH:

(a) County Bushman
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital # 22
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Massachusetts (b) County Caldwell 11
(c) City or town Covington 7
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME RICHARD L STUBBLEFIELD

3. (b) If veteran, name war _____ 3. (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 Hattie Stubblefield 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 23 1858
(Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Caldwell Massachusetts
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name John Stubblefield
13. Birthplace Illinois (City, town, or county) (State or foreign country)
14. Maiden name Martha Swanson
15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Hattie Stubblefield
(b) Address Covington, Mo
17. (a) Removal (b) Date thereof 10-29-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Brymer No

18. (a) Signature of funeral director Lucy Barnhart Home
(b) Address 218 South 10th St St Joseph Mo
19. (a) 10-29-42 (b) Doc Meyer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28
year 1942 hour 3 minute 30 M.
21. I hereby certify that I attended the deceased from Oct 16
16 1942 to Oct 28 1942
that I last saw him alive on Oct 28 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia 10-22-42

Due to Arteriosclerotic Heart Disease

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

Major findings: Of operations _____
Of autopsy 938

Duration

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? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
23. Signature D P Johnson (M. D. or other) MD
Address State Hospital # 2 Date signed 10-28-42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

E

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

Signed Victor J. Barry
Licensed Embalmer No. 42120
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 this body is not embalmed, fact should be so stated above.