

S. No. 2
M-2-43
5-17-39
P I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9114**

FILED APR 8 1946

Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **282**

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2420 N. Main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Springfield, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 2420 N. Main
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Miss Lucy Alice Stallcup

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased Sept. 1, 1862
(Month) (Day) (Year)

8. AGE: Years 83 Months 6 Days 26 If less than one day hr. _____ min. _____

9. Birthplace Greene Co., Missouari
(City, town, or county) (State or foreign country)

10. Usual occupation House Keeper

11. Industry or business _____

MOTHER FATHER { 12. Name James Stallcup
13. Birthplace UNK. Unknown 9
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Betty Clapp
15. Birthplace UNK. Tenn. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Orson Turner
(b) Address 2420 N. Main, SPFD, MO.

17. (a) Burial (b) Date thereof, 3/29/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Patterson (Cem.)

18. (a) Signature of funeral director Dunn Funeral Home
(b) Address Springfield, Mo.

19. (a) 3-28-46 (b) W. E. Handley
(Date received local register) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 27
Year 1946 hour 9 minute 30 AM.

21. I hereby certify that I attended the deceased from Jan 15, 1946 to Mar 27, 1946
that I last saw him alive on Mar 26, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral, recurrent
Due to Arteriosclerotic
Kidney
Due to Generalized Arteriosclerosis
Other conditions None
(Include pregnancy within 3 months of death)

Duration 6 weeks
10-15 yrs.

Major findings: Of operations none
Of autopsy none

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature R. C. Conrad (M. D. or other) MD
Address Springfield, Mo. Date signed 3-27-46

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

8041

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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..... *W. L. McLean*

Licensed Embalmer No. *2727*

P. O. Address..... *Spangfield, 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.

X