

FILED MAY 9 1946

State File No.

Registrar's No. 368

Registration District No. 128

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2239 North Boonville, /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 67 Years (Specify whether  
In this community 67 Years  
years, months or days)

3. (a) PRINT Sarah Ellen Stubblefield  
FULL NAME

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

4. Sex F M / 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife UNK. 6. (c) Age of husband or wife if alive Dec. years  
7. Birth date of deceased November 15, 1870  
(Month) (Day) (Year)

8. AGE: Years 75 Months 5 Days 15 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

12. Name George Chapman  
13. Birthplace Martinsville, Ill. /  
(City, town, or county) (State or foreign country)  
14. Maiden name Eliza Jane Morgan  
15. Birthplace Martinsville, Ill. /  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. S. Cope  
(b) Address Kansas City, Mo.  
17. (a) Burial (b) Date thereof May 2, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bellvue Cemetery

18. (a) Signature of funeral director W. L. Dunn  
(b) Address 629 W. Walnut, Springfield, Mo.  
19. (a) 5-2-46 (b) Dr. R. S. Handley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39  
(c) City or town Springfield 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2239 N. Boonville, 6  
(If rural, give location)  
(e) Citizen of foreign country? No 0  
(Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30th.  
year 1946 hour 4:00 minute 44 AM

21. I hereby certify that I attended the deceased from Apr 26 '46  
1946 to Apr 30 1946  
that I last saw W. alive on Apr 29 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death: Paralytic Stroke Duration 4 days  
Due to Essential Hypertension 10 years  
known 12 years

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: Of operations none Of autopsy none  
PHYSICIAN None  
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) (c) Means of injury  
23. Signature R. C. Conard (M. D. or other) M. D.  
Address Springfield, Mo. Date signed 5-1-46

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

MOTHER FATHER

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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..... *H. L. McCann* .....

Licensed Embalmer No. *2727* .....

P. O. Address. *Springfield 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