

FILED JUN 11 1946

Registration District No. 140

Primary Registration District No. 3024

Registrar's No. 34

1. PLACE OF DEATH:
(a) County Howard
(b) City or town Fayette, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community All her life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Howard 45
(c) City or town Fayette, Missouri 1
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Ida Stapleton
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Ben Stapleton 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 15 1877
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 12 year 1946 hour 7:00 minute A M.
21. I hereby certify that I attended the deceased from May 6 1946 to May 12 1946 that I last saw her alive on May 12 1946 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>3</u>	<u>27</u>	_____ hr. _____ min.

Immediate cause of death Pneumonia
Due to _____
Due to _____
Other conditions hypertension
(Include pregnancy within 3 months of death)

9. Birthplace Howard county Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business _____
12. Name Call Walker
13. Birthplace Howard County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Caroline Shock
15. Birthplace Howard County Missouri
(City, town, or county) (State or foreign country)
16. (a) Informant Willie Estill
(b) Address Fayette, Missouri
17. (a) Burial (b) Date thereof 5/14/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Fayette, Mo.
18. (a) Signature of funeral director Ralph A. Carr
(b) Address Fayette, Missouri
19. (a) 5-23-46 (b) Dorothy J. ...
(Data received local registrar) (Registrar's signature)

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? _____ (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 [Signature] (M. D. or other) _____
Address Fayette, MO Date signed 5-23-46

MOTHER FATHER

123

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

6-10-46

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

Ralph A. Carr

Licensed Embalmer No.

3340

P. O. Address

Gayette Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 34

Registration District No. 140 Primary Registration District No. 3024

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

3. (a) PRINT FULL NAME Ida Stepletter
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Jan 15
(Month) (Day) (Year)

8. AGE: Years 69 Months 3 Days _____ (If less than one day) _____
hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month mar 2
year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death pneumonia (bacter) Duration 10 days

Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy 108

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 M. P. Leach (M. D. or other) MD
Address Fayette, Mo Date signed 6-11-46

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

3883

16490