

No. 530
10.48

FILED MAR 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1547

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 202

1. PLACE OF DEATH a. COUNTY GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY GREENE		
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. LENGTH OF STAY (In this place) 9 weeks	c. CITY (If outside corporate limits, write RURAL and give township): OR TOWN REPUBLIC REPUBLIC TWP		d. STREET ADDRESS (If rural, give location) 9.W. SIDE TOWN 03915
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital					

3. NAME OF DECEASED (Type or Print) a. (First) ALPHA b. (Middle) IRENE c. (Last) STALCUP			4. DATE OF DEATH (Month) (Day) (Year) 3 4 1950			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 9-14-1908		9. AGE (In years last birthday) 41	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME ALBERT NANCE		13b. MOTHER'S MAIDEN NAME EFFIE BOURLAN		14. NAME OF HUSBAND OR WIFE OTIS DUDLEY STALCUP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME ADDRESS OTIS D. STALCUP, REPUBLIC, MO.		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Uremia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Glomerulonephritis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none			INTERVAL BETWEEN ONSET AND DEATH 3 mo. 5/2X
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19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? none		

22. I hereby certify that I attended the deceased from Dec 22, 1950, to March 4, 1950, that I last saw the deceased alive on March 4, 1950, and that death occurred at 3:50 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John S. Esch, M.D. U		23b. ADDRESS Republic, Mo	23c. DATE SIGNED 3-6-50
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24a. BURIAL (CREMATION, REMOVAL) (Specify) BURIAL	24b. DATE 3-7-1950	24c. NAME OF CEMETERY OR CREMATORY WADE CHAPEL CEMETERY	24d. LOCATION (City, town, or county) (State) GREENE MISSOURI	
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DATE REC'D BY LOCAL REG. 3-8-50	REGISTRAR'S SIGNATURE W.E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John Alan Harris Clever, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

6

APR 15 1950

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed: *John Dean Harris*

Licensed Embalmer No. *4390*

P. O. Address *Cleves, 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.