No. 300
10-48

FILED FEB 19 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4806

BIRTH NO. _____ REG. DIST. NO. 143 PRIMARY REG. DIST. NO. 5560 Registrar's No. _____

460
4

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

1. PLACE OF DEATH
a. COUNTY: Howell
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Willow Springs
c. LENGTH OF STAY (in this place): 19 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BROOMER REST HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: HOWELL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Willow SPRINGS
d. STREET ADDRESS (If rural, give location): 311 Walnut 0460 m

3. NAME OF DECEASED (Type or Print): a. (First) SAMUEL b. (Middle) P. c. (Last) STARK.

4. DATE OF DEATH (Month) Feb (Day) 2 (Year) 1952

5. SEX: m.
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): m
8. DATE OF BIRTH: March 11 1866
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min. <

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ind 1
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: Henry Stark
13b. MOTHER'S MAIDEN NAME: Jennie
14. NAME OF HUSBAND OR WIFE: Ida Ella Stark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Charles Fair ADDRESS: K.C. 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis, Coronary, Severe Lymphatic

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 4201
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/1, 1951, *to* 1/17, 1952, *that I last saw the deceased alive on* 1/17/52 10, *and that death occurred at* 8:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.B. Perkins, M.D.
23b. ADDRESS: Willow Springs, Mo.
23c. DATE SIGNED: 2/4/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Feb 4-52
24c. NAME OF CEMETERY OR CREMATORY: Centerview
24d. LOCATION (City, town, or county) (State): Centerview Mo.

DATE REC'D BY LOCAL REG.: 3652
REGISTRAR'S SIGNATURE: Marthalee Ballard 387
25. FUNERAL DIRECTOR'S SIGNATURE: Daylord V. Elliott ADDRESS: Cabool Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed James F. Genby

Signed _____
Student Embalmer

Licensed Embalmer No. 4718

P. O. Address Calvool, 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.