

FILED MAR 24 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009611

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 291

1. PLACE OF DEATH a. COUNTY <u>Greene</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Webster</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Seymour</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ozark Osteopathic</u>		Length of stay in lb <u>3 days</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hospital</u> <u>Sarah Rachel Stapp</u>			Middle	Last	4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27, 1888</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Christian County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jack Tucker</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Haden</u>		14. NAME OF HUSBAND OR WIFE <u>George A. Stapp, Deceased</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>	17. INFORMANT Address <u>Mrs. Ruby Swearengin, Rogersville, Missouri</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Paralysis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Thrombotic Encephalomalacia with Cerebral Hemorrhage</u>					<u>6 days</u>	
DUE TO (c) <u>Arteriosclerosis</u>					<u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonia</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <u>5:35 P.M.</u> Month, Day, Year a.m. <u>3-18-58</u> p.m.						
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from <u>November 1957</u> to <u>March 18, 1958</u> and last saw her alive on <u>March 18, 1958</u> Death occurred at <u>5:35 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Andrew Mattheick, D.O.</u>		(Degree or title)	22b. ADDRESS <u>700 E. Sunshine Springfield, Missouri</u>		22c. DATE SIGNED <u>3/18/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>3-18-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNION CHAPEL</u>		23d. LOCATION (City, town, or county) <u>Webster County MO.</u>	(State)	
24. FUNERAL DIRECTOR <u>Nox &amp; Miller</u>		ADDRESS <u>Marionville Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-20-58</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300  
1-57

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No symptoms were observed.

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.

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Max S Miller

Licensed Embalmer No. 4720

P. O. Address Manassas Va

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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