

Health,  
& Welfare  
Public  
Service

DR STANLEY ROPER

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036106

STATE FILE NUMBER

FILED NOV 3 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1008A

300  
1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SPRINGFIELD</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>SPFD. BAPTIST HOSP. LIFE</b>			Length of stay in 1b	d. STREET (If outside, give location) ADDRESS <b>039 1534 NO. CLAY</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELMER L. STIGALL</b>				4. DATE OF DEATH Month Day Year <b>OCT, 20, 1958</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE, 2, 1888</b>		9. AGE (In years last birthday) <b>70</b> 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) <b>RET. CUSTODIAN OF SCHOOLS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOLS</b>		11. BIRTHPLACE (City and state or country) <b>GREENE, COUNTY, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>ROBERT ALMON</b>			13b. MOTHER'S MAIDEN NAME <b>ALTA ANN JONES</b>			14. NAME OF HUSBAND OR WIFE <b>BEULAH STIGALL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS BEULAH STIGALL, SPRINGFIELD, MO</b>			
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>Thrombosis, coronary acute</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerosis, generalized severe</u> DUE TO (c) <u>4201</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 yrs - 10 mos.</u>	
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 Month, Day, Year a.m. 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>19 Jan 57</u> to <u>20 Oct 58</u> and last saw <sup>her</sup> alive on <u>11 Oct 58</u> Death occurred at <u>APPROX. 11:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. S. Roper M.D.</u> (Degree or title)			22b. ADDRESS <u>Clark, Mo</u>			22c. DATE SIGNED <u>24 Oct 58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>OCT, 23, 58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>EASTLAWN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>SPRINGFIELD, MISSOURI</b>			
24. FUNERAL DIRECTOR <b>HERMAN LOHMEYER, SPRINGFIELD, MO</b>			25. DATE RECD. BY LOCAL REG. <b>10-27-58</b>		26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>		

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 *Gene L. Loney* .....

Licensed Embalmer No. *4734*  
P. O. Address *Springfield*

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.