

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**60-010314**

LED VS **MAR 24 1960**  
 DEED

73

Primary Registration District No. **5291**

Registrar's No. **73**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Clay</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>CLAY</b>			
b. CITY (if outside corporate limits, give TOWNSHIP only) <b>Liberty</b>		Length of stay in 1b <b>5 mo.</b>		c. CITY OR TOWN <b>Minneville</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>I.O.O.F. Home.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>Rt. 13. N.K.C.</b>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>MONROE</b> Last <b>Stapp</b>				4. DATE OF DEATH Month <b>3</b> - Day <b>10</b> - Year <b>60</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1-4-1881</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, with if retired) <b>Retired Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Clay Co.</b>		11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>James M. Stapp</b>			13b. MOTHER'S MAIDEN NAME <b>Sara Jane Burns</b>		14. NAME OF HUSBAND OR WIFE <b>Jessie Stapp</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>500-03-8842</b>		17. INFORMANT <b>Glenn Stapp Clay Co. 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) <b>Exhaustion Failure</b> DUE TO (b) <b>Pneumonia</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>Indef</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Coronary Arteriosclerosis - 5%</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT WORK <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 <b>Nov. 1954</b> to <b>Nov 10, 1960</b> and last saw him alive on <b>3/3/60</b> Death occurred at <b>2:33 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Glenn W. Henderson MD</b>				22b. ADDRESS <b>Liberty, Mo</b>		22c. DATE SIGNED <b>3/10/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-12-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cem.</b>		23d. LOCATION (City, town, or county) <b>Liberty Mo.</b>		23e. STATE <b>Mo.</b>	
24. FUNERAL DIRECTOR <b>D. W. Newcomer Sons</b>			ADDRESS <b>N.K.C.</b>	25. DATE RECD. BY LOCAL REG. <b>3-19-60</b>	26. REGISTRAR'S SIGNATURE <b>Marebela Kern</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Lowler

17 Corp.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed Robert W. F. Linnick

Licensed Embalmer No. 4848

P. O. Address N. C. 17

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.