

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 26 1957

State File No. 19997

BIRTH NO. _____		REG. DIST. NO. <u>H</u>		PRIMARY REG. DIST. NO. <u>5044</u>		Registrar's No. <u>41</u>	
1. PLACE OF DEATH a. COUNTY <u>Barry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: resident before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Barry</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Washburn</u>		c. LENGTH OF STAY (in this place) <u>44 yrs</u>		c. CITY OR TOWN <u>Washburn</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>West part of Washburn</u>				e. STREET ADDRESS (If rural, give location) <u>003 West Part of Washburn</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JOSEPH</u> b. (Middle) <u>ALBERT</u> c. (Last) <u>STINECIPHER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6 13 1957</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 9, 1873</u>		9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>4</u>	IF UNDER 24 Hrs. Hours <u> </u> Mins. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Salem, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>R.E. Stinecipher</u>		13b. MOTHER'S MAIDEN NAME <u>unkown</u>		14. NAME OF HUSBAND OR WIFE <u>Nancy Charotta</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Charley Stinecipher Washburn, Mo.</u>				
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) <u>Acute Congestive Heart Failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Essential Hypertension</u>					<u>15 years</u>	
	DUE TO (c) <u>Prostatic Hypertrophy</u>					<u>10 years</u>	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>443x</u>				20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 10</u> , 19 <u>36</u> , to <u>June 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>57</u> , and that death occurred at <u>3 A.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E.E. McDonald M.D.</u>				23b. ADDRESS <u>Cassville, Mo.</u>		23c. DATE SIGNED <u>6-17-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-16-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cargile Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Barry Co. Missouri</u>		
DATE REC'D BY LOCAL REG. <u>6-17-57</u>		REGISTRAR'S SIGNATURE <u>Grace Williams</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Paul E. Williams</u> <u>W. Gibson Chapel Cassville, Mo.</u>			

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

10-0

BARRY COUNTY HEALTH UNIT
CASSVILLE, MO.

NO. 657-105

DATE REC. 6-24-57

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 Doyle E. Wilkerson
Licensed Embalmer No. 488
P. O. Address Cassville

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.