

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-014055

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 11 Primary Registration District No. 5043 Registrar's No. 34

VS 300  
Rev. 4/59

10050

20050

3

4 1

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94200

10

11

1290-0

131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

<b>FILED APR 18 1962</b>	
1. PLACE OF DEATH	
a. COUNTY <b>BARRY</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SELIGMAN</b>	a. STATE <b>MO.</b> b. COUNTY <b>BARRY</b>
Length of stay in b <b>57 yrs.</b>	c. CITY OR TOWN <b>SELIGMAN</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	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH
First <b>BLANCHE</b> Middle <b>M.</b> Last <b>STAPLETON</b>	Month <b>APRIL</b> Day <b>7</b> Year <b>1962</b>
5. SEX <b>F</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>9/29/82</b>
9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>
11. BIRTHPLACE (City and state or country) <b>Ohio</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Thomas Hershey</b>	13b. MOTHER'S MAIDEN NAME <b>Maria M. McElvaine</b>
14. NAME OF HUSBAND OR WIFE <b>W.A. Stapleton, dec.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>
17. INFORMANT <b>Eleanor Stewart, Seligman, Mo.</b>	Address
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>Respiratory failure</b>	
DUE TO (b) <b>Cerebral Vascular Accident</b>	
DUE TO (c) <b>Arteriosclerotic Heart Disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
PART III. If deceased was female was there a pregnancy, in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 a.m. p.m. Month, Day, Year	
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>3-28-61</b> to <b>4-7-62</b> and last saw her alive on <b>4-1-62</b>	
Death occurred at <b>6:45 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>D. P. Pillestrom, MD</b>	22b. ADDRESS <b>Rogers, Arkansas</b>
22c. DATE SIGNED <b>4-9-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>4/10/62</b>
23c. NAME OF CEMETERY OR CREMATORY <b>Moorehead Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Lamar, Missouri</b>
24. FUNERAL DIRECTOR <b>Doyle E. Williamson, Cassville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4-9-1962</b>
26. REGISTRAR'S SIGNATURE <b>Grace Williams</b>	

**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 Paul E. Williams

Licensed Embalmer No. 4883

P. O. Address Cassville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

Removal Permit issued 4-9-62 JWB