

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

24048

1. PLACE OF DEATH

County Carroll Registration District No. 135
Township Wakanda Primary Registration District No. 5793
City _____ (No. _____) St. _____ Ward _____

File No. _____
Registered No. 73

2. FULL NAME

Mr William Stanley
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1/1/67

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>62</u>	<u>6</u>	<u>6</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Carroll County
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Moses Stanley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Dessan Hart

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Callaway Co
(STATE OR COUNTRY) Missouri

14. INFORMANT Mrs Lydia Cooper
(Address) Carrollton Mo

15. FILED 7/8, 1929 Mrs E. E. Farnham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-7 1929

17. I HEREBY CERTIFY, That I attended deceased from 7-1 1929 to 7-6 1929 that I last saw him alive on 7-6 1929, and that death occurred, on the date stated above, at 1 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral
Liver

CONTRIBUTORY (SECONDARY) 11/6 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 11/6 (duration) yrs. mos. ds.

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) William G. Atwood M. D.

7/8, 1929 (Address) Carrollton, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Paulell Cem DATE OF BURIAL 7/8/29

20. UNDERTAKER Willis Bros ADDRESS Carrollton Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 23 1929

