

Registration District No. 17

Primary Registration District No. 5-1-1

Registrar's No.

1. PLACE OF DEATH:

(a) County ATCHISON  
 (b) City or town RURAL, CLARK, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME MILTON STANFORD STACKHOUSE

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED  
 6. (b) Name of husband or wife ELIZABETH STACKHOUSE 6. (c) Age of husband or wife if alive ✓ years  
 7. Birth date of deceased 10-16-1852  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
88 8 14 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace UNKNOWN PENN.  
 (City, town, or county) (State or foreign country)

10. Usual occupation FARMER.

11. Industry or business

MOTHER FATHER { 12. Name STANFORD STACKHOUSE  
 13. Birthplace UNKNOWN PA  
 (City, town, or county) (State or foreign country)  
 14. Maiden name M. MARKIN  
 15. Birthplace WEDDWAY CO. MO.  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature V. B. Stackhouse  
 (b) Address ROCK FORT. MO  
 17. (a) BURIAL (b) Date thereof 7-2-1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation HUNTER  
 18. (a) Signature of funeral director Beat Buchala  
 (b) Address Rock Fort Mo  
 19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30 year 1941 hour 6:10 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from June 25, 1941, to June 30, 1941; that I last saw him alive on June 28, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 3 days

Due to Arterio Sclerosis 9 yrs.

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) LDN

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
15 (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. Davis (M. D. or other) \_\_\_\_\_  
 Address Rock Fort Mo Date signed 7-1-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

MARGIN RESERVED FOR BINDING

FORM 5-17-39

Rev. 5-17-39 I X19511

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Grady Bartholomew*

Licensed Embalmer No.....

*3173*

P. O. Address.....

*Rock Pt. 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 this body is not embalmed, above space should be left blank.**

Registration District No. 17

Primary Registration District No. 3021

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Atchison  
(b) City or town Clark Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison  
(c) City or town Fairfax  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) R. 7. W.  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Milton Stanford Stack House  
3. (b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month June day 30  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced wid

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
alive \_\_\_\_\_ year \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years 88 Months 8 Days 14 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

9. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Aug 26-1941 (b) Halter B. Black  
(Date received local registrar) (Registrar's signature)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. H. Davis (M. D. or other) \_\_\_\_\_  
Address Fairfax Mo Date signed \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

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

MOTHER FATHER

