

FILED JAN 25 1946
Registration District No. **5625**

Primary Registration District No. **4531**

Registrar's No. **36**

1. PLACE OF DEATH:
(a) County **Warren**
(b) City or town **Warrenton**
(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 **4 Months** years, months or days)

3. (a) PRINT FULL NAME **MAY OLIVE STANSBURY**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Oscar E. Stansbury** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Jan 3 1864**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 11 11 min.

9. Birthplace **Bowen Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Home duties**

11. Industry or business _____

MOTHER FATHER
12. Name **Thomas Simpson**
13. Birthplace **Bowen Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Ruth Ann Halbert**
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Leora Powell**
(b) Address **Warrenton, Mo**

17. (a) **Burial** (b) Date thereof **Dec 19-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis**

18. (a) Signature of funeral director **Wentzville, Mo**
(b) Address _____

19. (a) **Dec 20, 1945** (b) **Mrs Hugo Luttman**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** County **St. Charles**
(c) City or town **Forest Hill, Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **Rural**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **14**
year **1945** hour **7** minute **50 A.M.**

21. I hereby certify that I attended the deceased from **December 15**, 1945, to **December 14**, 1945;
that I last saw him alive on **December 13**, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Heart Failure - Myocardial
Due to **Hypertension**
Due to **Arteriosclerotic Interstitial**
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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. B. Kellum** (M.D. or other)
Address **Wayle City, Mo** Date signed **12/14/45**

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

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 1-4-46

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 T. E. Pitman

Licensed Embalmer No. 2711
P. O. Address Wentzville, 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, fact should be so stated above.

Registration District No. 262

Primary Registration District No. 45-31

Registrar's No. 36

1. PLACE OF DEATH:

(a) County Warren
 (b) City or town Warrenton
(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)

3. (a) PRINT FULL NAME May Olive Stansbury
 3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: Jan (Month) 26 (Day) 1869 (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14
 year 1945 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____; 19____;
 that I last saw him _____ after on _____ 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration _____

Due to _____
 Due to Chronic nephritis
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy 1318
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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 John B. Kellomaki M.D. (M. D. or other) _____
 Address Highway City, Mo. Date signed 1/16/45

SUPPLEMENTARY

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

B
15
3880

42709