

V. S. No. 2  
00M-3-43  
Rev. 5-17-39  
I X37823

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26469**  
Registrar's No. **290**

**FILED** SEP 6 1946

Registration District No. **77** Primary Registration District No. **9008**

14  
1  
2

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

25815

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton

(c) Name of hospital or institution: State Hospital no 1 2  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 4 months 14 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME LAURA STANLEY

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 widow

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

7. Birth date of deceased Dec 28 1838  
(Month) (Day) (Year)

8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

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

MOTHER FATHER

12. Name Daniel Hocker

13. Birthplace Pennsylvania  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Sellers

15. Birthplace ?  
(City, town, or county) (State or foreign country)

16. (a) Informant Records  
(b) Address Fulton, Mo

17. (a) Removal (b) Date thereof 8/25/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Kan

18. (a) Signature of funeral director Henry Murrin

(b) Address 712 Court, Fulton, Mo

19. (a) 8-25-1946 (b) Joan Mosauer Kuff  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 1116 Forest (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29 it  
year 1946 hour 8 minute 40 P. M.

21. I hereby certify that I attended the deceased from Aug 23  
to Aug 24 1946  
that I last saw her alive on Aug 24 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death lobar pneumonia (terminal) Duration 3 days

Due to chronic myocarditis 1 year

Due to arterio sclerosis 4 yrs

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

Major findings: Of operations 108

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

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e). Means of injury fall

23. Signature Joseph Imperatrice (M. D. or other) Med.  
Address State Hospital Date signed Aug 25 46

RECEIVED  
District Health Officer No. 91  
District File Number 8-46-48  
Date Filed 9-4-46

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  
Harold M. Douglas, Registered Apprentice No. 410  
working under my personal supervision.

Signed J. J. Ridd  
Licensed Embalmer No. 2555  
P. O. Address \_\_\_\_\_

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.