

No. 2
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5-17-39
I X47070

FILED JUL 11 1947
Registration District No. **128**

Primary Registration District No. **2000**

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Burge Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 hours
(Specify whether years, months or days)

In this community 15 hrs

3. (a) PRINT FULL NAME DANNY LEE STACEY

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June 24, 1947
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	<u>15 hr. 10 min.</u>

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

10. Usual occupation Infant

11. Industry or business

MOTHER FATHER { 12. Name Max Allen Stacey

{ 13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

{ 14. Maiden name Crodellia Corisant

{ 15. Birthplace Unknown Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Burge Hospital

(b) Address Springfield, Missouri

17. (a) Burial (b) Date thereof 6/25/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clear Creek Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri

19. (a) 6-28-47 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene **39**

(c) City or town Springfield **2**
(If outside city or town limits, write "RURAL")

(d) Street No. Burge Hospital **6**
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) **0**

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24,
year 1947 hour 4: minute 00 P.M.A.M.

21. I hereby certify that I attended the deceased from June 24th only
1947 to June 24th 1947
that I last saw her alive on June 24th 1947
and that death occurred on the day and hour stated above.

Immediate cause of death Premature birth (wt 1 1/2 lbs) 16 hrs.

Duration _____

Due to ✓

Due to ✓

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none **159**

Of operations _____

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? ✓

While at work _____ (Specify type of place)

23. Signature John H. Selsby (M. D. or other) M.D.
Address Springfield Mo Date signed 6-26-47

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.....

Lee Mason

....., Registered Apprentice No. *477*

working under my personal supervision.

Signed.....

Jessie E. Kudy

Licensed Embalmer No. *2831*

P. O. Address *Springfield 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.