

FILED JUL 12 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21938**

No. 500
10-48

140

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

BIRTH NO. _____ REG. DIST. NO. 378 PRIMARY REG. DIST. NO. 6285 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <u>Wright</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>mo</u> b. COUNTY <u>Wright</u>	
b. CITY OR TOWN <u>Rural Mt. Vernon Twp</u>		c. CITY OR TOWN <u>mtn grace</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) <u>426 E. South St</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>On way to Springfield the hospital</u>		1140	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Donald</u> b. (Middle) <u>Ray</u> c. (Last) <u>Stanley</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 22, 1954</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Child</u>	8. DATE OF BIRTH <u>July 18, 1951</u>
9. AGE (In years last birthday) <u>2</u> Months <u>11</u> Days <u>4</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Roswell, Ga. U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Charles Stanley</u>		13b. MOTHER'S MAIDEN NAME <u>Marion June Sanders</u>	
14. NAME OF HUSBAND OR WIFE <u>Child</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Marion June Stanley</u> ADDRESS <u>mtn grace</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Waterhouse - Friedreichsen syndrome</u> INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Acute meningococcus septicemic</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>0571</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>autopsied</u> <u>6-22, 1954</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.	
23a. SIGNATURE <u>E. D. Bannan</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>Burge Hospital Springfield Mo</u>	
23c. DATE SIGNED <u>6-23-54</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>6-24-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>SEUBBS</u>	
24d. LOCATION (City, town, or county) (State) <u>MTN GROVE, MO.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leslie W. Wicks</u> ADDRESS <u>mtn grace mo.</u>	
DATE REC'D BY LOCAL REG. <u>6-29-54</u>		REGISTRAR'S SIGNATURE <u>A. B. Ames</u> 348-U	

WRIGHT CO. HEALTH DEPT.
County File Number 254-27
Date Filed 7-10-54

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Frank Gable

Licensed Embalmer No. 414
P. O. Address Intergo

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.