

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 12 1955

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 4

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| 1. PLACE OF DEATH a. COUNTY <u>Adair</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkville</u> | | c. CITY OR TOWN <u>Kirkville</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) <u>10 yrs</u> | | e. STREET ADDRESS (If rural, give location) <u>703 W. Pierce</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>703 W. Pierce</u> | | | |

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| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Richard</u> b. (Middle) Richard <u>M.</u> c. (Last) <u>Stanley</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>1-3-55</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u> | 8. DATE OF BIRTH <u>11-21-1890</u> | 9. AGE (In years last birthday) <u>64</u> | IF UNDER 1 YEAR Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>Adair Co., Missouri</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | | | | |

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| 13a. FATHER'S NAME <u>Samuel Stanley</u> | | 13b. MOTHER'S MAIDEN NAME <u>Martha Gates</u> | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>484-10-9902</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Harry Stanley, Kirkville, Mo.</u> | |

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| 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 | | INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) | 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 1-1-1955 to 1-3-1955, that I last saw the deceased alive on 1-1-1955, and that death occurred at 2:15 p.m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>C. H. Martin, M.D.</u> | 23b. ADDRESS <u>Kirkville, Mo.</u> | 23c. DATE SIGNED <u>1-6-55</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>1-6-1955</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Novinger Cemetery</u> |
| 24d. LOCATION (City, town, or county) (State) <u>Novinger, Mo.</u> | | |

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| DATE REC'D BY LOCAL REG. <u>1-6-55</u> | REGISTRAR'S SIGNATURE <u>Kate Lambert</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>David K. Sigal, Kirkville, Mo.</u> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Harold H. Kujala*

Licensed Embalmer No. *429*

P. O. Address *Kenbure*

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.