

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30254

State File No. ....

FILED OCT 13 1955

BIRTH NO. 78589-55 REG. DIST. NO. 240 PRIMARY REG. DIST. NO. 4358 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Lilbourn</u>	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>Canalou</u>	d. Is Residence within limits of a city or incorporated town? <input type="checkbox"/> No. <u>0</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chastain's Clinic</u>		f. STREET ADDRESS (If rural, give location) <u>4 miles South of Canalou</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Baby</u> b. (Middle) <u>Boy</u> c. (Last) <u>Stanford</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 30 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Sept. 30 1955</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 2 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Lilbourn, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Jr. Floyd Stanford</u>	13b. MOTHER'S MAIDEN NAME <u>Bonnie Flowers</u>	14. NAME OF HUSBAND OR WIFE
--	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Jr. Floyd Stanford</u>	ADDRESS <u>Canalou, Mo.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>5 Month Lack of Strength to Live</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>under oxygen - 2 1/2 hours</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>776x</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input 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) m.	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 Sept 30, 1955 to Sept 30, 1955, that I last saw the deceased alive on Sept 30, 1955, and that death occurred at 10:30 m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. H. C. Chastain</u> (Degree or Title)	23b. ADDRESS <u>Lilbourn, Mo.</u>	23c. DATE SIGNED <u>10-6-55</u>
--	-----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-1-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mounds Park Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Lilbourn, Mo.</u>
---	--------------------------	--	--

DATE REC'D BY LOCAL REG. <u>10-6-55</u>	REGISTRAR'S SIGNATURE <u>H. L. Gonder Deputy</u> 2180	25. FUNERAL DIRECTOR'S SIGNATURE <u>Friends</u>	ADDRESS
---	---	---	---------

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

to. 300  
0. 48

DATE RECEIVED OCT 10 1955  
NEW MADRID CO. HEALTH CENTER  
P. J. S.

**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.....

Licensed Embalmer No.....

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