

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006504

STATE FILE NUMBER

13

FILED FEB 19 1959

Registration District No. 245

Primary Registration District No. 5834

Registrar's No.

300  
-57

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>NEWTON</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>NEWTON</b>                   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>MARION TWP.</b>  |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | c. CITY OR TOWN <b>GRANBY</b>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>GRANBY Rt. 1</b>   |                                  | Length of stay in 1b<br><b>25 YR.</b>   | d. STREET ADDRESS (If outside, give location)<br><b>RED # 1 GRANBY</b>                               |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>CHARLES W. STANLEY</b>  |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>JAN 19 1959</b>   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 4, 1887</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>AGRICULTURE</b>   | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.<br><b>71</b> Months Days Hours Min. |
| 11. BIRTHPLACE (City and state or country)<br><b>ARK.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13a. FATHER'S NAME<br><b>WILLIAM STANLEY</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>SARAH HENCEY</b>  | 14. NAME OF HUSBAND OR WIFE<br><b>MARY STANLEY</b>   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>498-40-2319</b>   | 17. INFORMANT Address<br><b>MRS. MARY STANLEY - GRANBY</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Chronic glomerulonephritis</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>572X</b>  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |                                  |   |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |                                  | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |  |
| 21. I attended the deceased from <b>Dec 18, 1958</b> to <b>Jan 18, 1959</b> and last saw <sup>her</sup> him alive on <b>Jan 18, 1959</b><br>Death occurred at <b>7:20 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                                  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Hubert W. Gerber, M.D.</b>  |                                  | 22b. ADDRESS<br><b>Carthage, Mo.</b>  | 22c. DATE SIGNED<br><b>2-9-59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE<br><b>JAN 23, 1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SPRING VALLEY</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>NEWTON CO. MO.</b>                               |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Harbert Gerber, Joplin</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>Feb. 11, 1959</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Melvin C. Bowman, MD.</b>  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

DATE FILED  
259-230  
1959

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 *Dale Glover* .....

Licensed Embalmer No. 4593  
P. O. Address *Joplin, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.