

Health, Welfare, Public Service, 000-556, diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016613  
STATE FILE NUMBER

8 FILED MAY 18 1959 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 150

1. PLACE OF DEATH a. COUNTY <i>Adair</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY <i>Schuyler</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Herkoville</i>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Lancaster</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>1501H</i>	Length of stay in lb <i>72H</i>	d. STREET-ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>THOMAS C STACEY</i>			4. DATE OF DEATH Month <i>May</i> Day <i>11</i> Year <i>59</i>		
5. SEX <i>m.</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 14/1880</i>	9. AGE (In years last birthday) <i>78</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Schuyler</i>		12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME <i>William L Stacey</i>			14. MOTHER'S MAIDEN NAME <i>Harriett O'Briant</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Lena Stacey</i> Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Medullary Failure</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Ventricular fibrillation</i>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Intestinal obstruction - acute aneurysm</i>		19. WAS AUTOPSY PERFORMED? 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 Hour <i>12:07</i> Month, Day, Year a. m. <i>p.</i> p. m.		

20d. INJURY OCCURRED WHILE AT WORK <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 <i>Lancaster Mo.</i>	COUNTY	STATE
21. I attended the deceased from <i>5-10-59</i> to <i>5-11-59</i> and last saw <sup>him</sup> alive on <i>5-11-59</i> Death occurred at <i>12:07 p.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Depr. or title) <i>Addison Humboldt</i>		22b. ADDRESS <i>Lancaster Mo.</i>	22c. DATE SIGNED <i>5-11-59</i>	

23a. BURIAL, CREATION, REMOVAL (Specify)	23b. DATE <i>1959 May 13</i>	23c. NAME OF CEMETERY OR CREMATORY <i>LOCK</i>	23d. LOCATION (City, town, or county) (State) <i>Lancaster Mo</i>
24. FUNERAL DIRECTOR <i>O C Fenton, Lancaster, Mo</i>		25. DATE RECD. BY LOCAL REG. <i>5-12-1959</i>	26. REGISTRAR'S SIGNATURE <i>Doris W. Ratliff</i>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
ADDISON HOMB.S.D.O.

6961 8 NNC

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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 *P. J. Fenton*.....

Licensed Embalmer No. *307*

P. O. Address *Lane*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.