

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Platte

Registration District No. 1099

File No. 29029

Township Littleton

Primary Registration District No. 3868

Registered No. _____

City _____

(No. _____)

St. _____

Ward _____

2. FULL NAME Ray Stanfield

(a) Residence, No. _____

St. _____

Ward. _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Male

White

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 19-1930

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

1

6

8

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

none

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Peoria Mo

FATHER 13. NAME Lee Stanfield

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Platte Mo

MOTHER 15. MAIDEN NAME Allie Gross

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Lee Stanfield

18. BURIAL, CREMATION, OR REMOVAL

PLACE Highway DATE 9-10-1931

19. UNDERTAKER (ADDRESS)

20. FILED 9-10-1931 Opal Wells Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 9-1931

22. I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1931, to Aug 9th, 1931

I last saw him alive on no calls made. Death is said

to have occurred on the date stated above, at 6:50 p.m.

The principal cause of death and related causes of importance were as follows:

Colitis

Date of onset

Other contributory causes of importance:

Name of operation _____

Date of _____

What test confirmed diagnosis Physical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

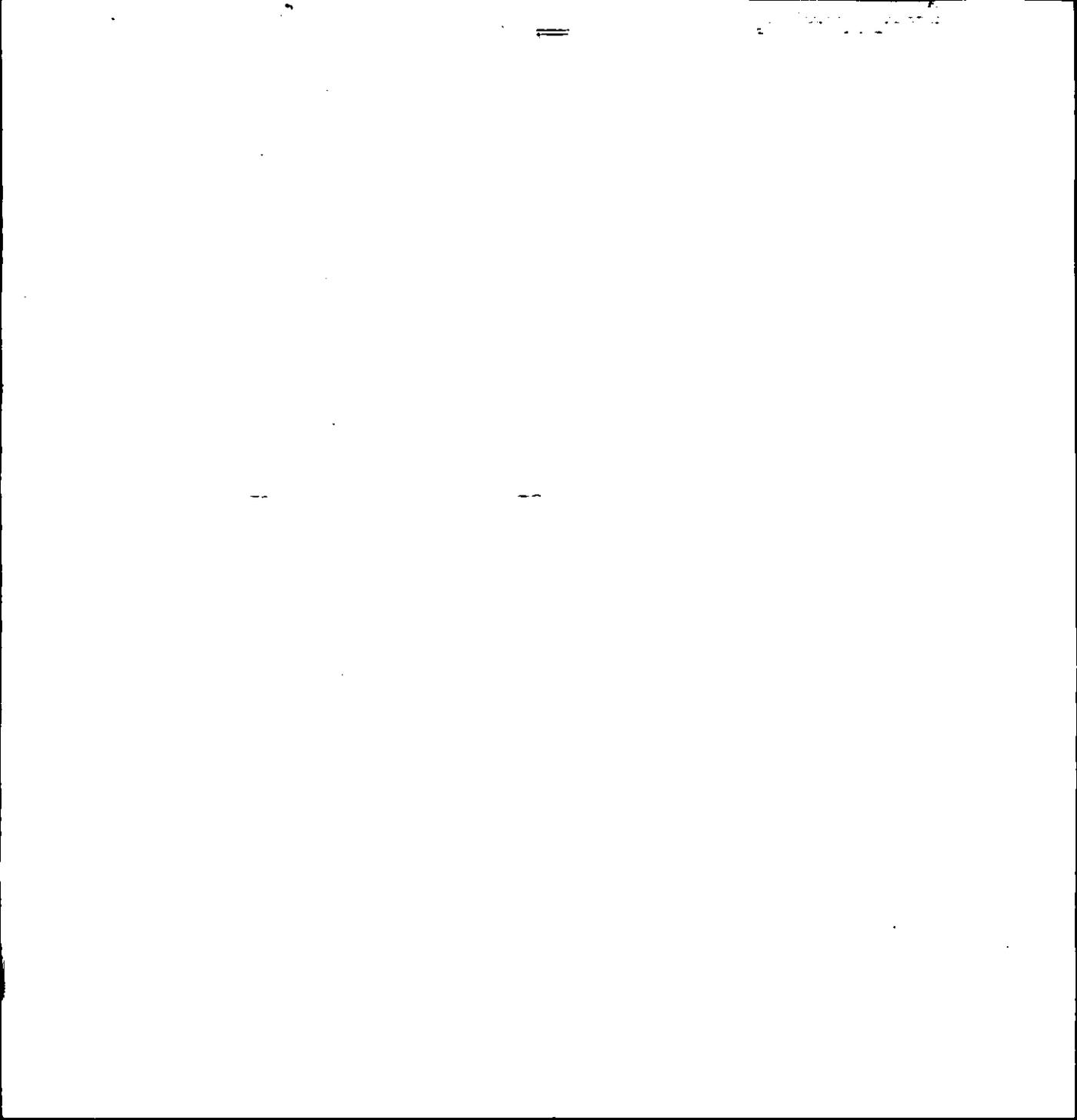
24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) J. M. Calister

M. D.

(Address) Stanfield Mo



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Missouri Registration District No. 10.99 File No. _____
 Township Little River Primary Registration District No. 3-868 Registered No. _____
 City _____ No. _____ St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (after the word) S

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND of (or) WIFE of

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

14. INFORMANT _____
 (Address)

15. FILED 10-10-31 Opal Weeli REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9 1931

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, (that I last saw him alive on _____, 19____, and that death occurred, on the date stated above) _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

Walley Worth Wardell

SEE FOR CERTIFICATE. UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-29029