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

Do not use this space.

15055

1. PLACE OF DEATH
105 County Sullivan — Registration District No. 852 — File No.
Township Pleasant Hill — Primary Registration District No. 6122 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Hannah Wright Stanforth

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MAY 31 1932

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND~~ OF (OR) WIFE OF Amos F. Stanforth

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 7, 1848

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	83	5	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Clarke County, Ohio. 20
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Peter P. Cox.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Jamestown Va.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Eleanor Beall,
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

14. INFORMANT Mrs. H. L. Knight
(Address) Cora, Mo.

15. FILED Apr 9, 1932 Mayme Calfee REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 6 1932

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 1:45 p.m. —

16a THE CAUSE OF DEATH* WAS AS FOLLOWS:
I was consulted by Mr. Knight (son-in-law of Mrs. Stanforth) to prescribe for her nervousness — by Amytal gr 1 ss at bed time — Have never seen Mrs. Stanforth —
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) — Senility —
..... (duration) ..... yrs. — mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no —
WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) Ew Hickson, M. D.
April 6, 1932 (Address) Milan, Mo —

*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
Mt Zion Cem. Twp. Pleasant Hill	Apr. 8 1932
20. UNDERTAKER C. A. Schoene	ADDRESS Milan, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD