

REC'D MAR 17 1938

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

7039
 Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 408
 (b) Township _____ Primary Registration District No. 3020 Registered No. _____
 (c) City Carthage (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred 6 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Cora Lee Stanton 353
 (a) Residence, No. 623 E. Central St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lee H. Stanton
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 3, 1870
 7. AGE YEARS 67 MONTHS 10 DAYS 13 If LESS than 1 day,hrs. ormin.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Springfield (STATE OR COUNTRY) Missouri

FATHER 13. NAME John Z. Stanton

14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Illinois

MOTHER 15. MAIDEN NAME Lillie Lemon

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

17. INFORMANT Lee H. Stanton (ADDRESS) 623 E. Central - Carthage

18. BURIAL, CREMATION, OR REMOVAL PLACE Park Cemetery DATE Feb. 28, 1938

19. FUNERAL DIRECTOR Fred Mortuary (ADDRESS) Carthage, Missouri

20. FILED Feb 28, 1938 W. M. Howard Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 26, 1938

22. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1938 to Feb 26, 1938
 I last saw her alive on Feb 26, 1938. Death is said to have occurred on the date stated above, at 9:30 P.M.
 The principal cause of death and related causes of importance were as follows:

Cerebral emboli
(origin unknown)
 Date of onset 2/24/38

Other contributory causes of importance: myocarditis
uremia
93
(?)
2/24/38

Name of operation none 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? no 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) George H. Wood, M. D.
 (Address) Carthage Mo.

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(Licensed Embalmer's Statement on Reverse Side)

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.

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STATEMENT BY LICENSED EMBALMER

I, Emma R. Knell, Licensed Embalmer No. 391

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No. or by Registered Apprentice No.
working under my personal supervision.

Signed Emma R. Knell

Licensed Embalmer No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

STATE OF OHIO
DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
COLUMBUS, OHIO

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

7039
Do not use this space.

1. PLACE OF DEATH
 (a) County Jasper Registration District No. 406
 (b) Township _____ Primary Registration District No. 3020 Registered No. _____
 (c) City Carthage (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Cora Kate Steaton
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
 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.
69 10 13
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 FATHER 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19.
 19. FUNERAL DIRECTOR (ADDRESS) _____
 20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 26, 1958
 22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Cerebral embolus Date of onset _____
Cause of Venous Th.
myocarditis
venous.
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 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? _____
 If so, specify _____
 (Signed) George H. Wood, M. D.
 (Address) Carthage Mo

SUPPLEMENT

Local Registrar

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 A statement of OCCUPATION is very important.
 PHYSICIAN'S SIGNATURE AND STATE OF DEATH IN PLAIN TERMS, so that it may be properly understood.
 REGISTERED IN PLAIN TERMS, so that it may be properly understood.
 PHYSICIAN'S SIGNATURE AND STATE OF DEATH IN PLAIN TERMS, so that it may be properly understood.

S-7039