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.

MAY 22 1939

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

3

15339
Do not use this space.

1. PLACE OF DEATH
(a) County Lawrence Registration District No. 470
(b) Township North Mt Vernon Primary Registration District No. 5633 Registered No. 61
(c) City Mt. Vernon, Mo (d) Street No. Missouri State Sanatorium 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. 2 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Parker Stanfield
(a) Residence, No. Steele, Missouri St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Jan. 31, 1887
7. AGE: YEARS 52 MONTHS 2 DAYS 25 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Cotton Buyer
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) 1937
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Cerrogordo Tennessee

FATHER
13. NAME: John A. Stanfield
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Wainsborough Tennessee

MOTHER
15. MAIDEN NAME: Elizabeth Copeland
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Wainsborough Tennessee

17. INFORMANT (ADDRESS): E. McMichael, Record Clerk Missouri State Sanatorium
18. BURIAL, CREMATION, OR REMOVAL
PLACE Steele Mo DATE Apr. 25 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): George B Orr Mt Vernon Mo
20. FILED 4, 26, 1939 P. A. Holmes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 24, 1939
22. I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1939 to April 24 1939
I last saw him alive on Apr. 24, 1939. Death is said to have occurred on the date stated above, at 10:05 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary tuberculosis	1933
22	

Other contributory causes of importance:

Tuberculous Laryngitis	1938
Tuberculous Meningitis	1939

Name of operation None Date of
What test confirmed diagnosis? Sputum Was there an autopsy? yes

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 A S Tucker, M. D.
(Address) Mt Vernon Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 6-5-39-994
Date Filed MAY 10 1939

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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.