

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

3322  
Do not use this space.

*JAN 23 1940 2*

1. PLACE OF DEATH  
 (a) County..... Pettis Registration District No..... 668  
 (b) Township.....                      Primary Registration District No.....  
 (c) City..... Sedalia (d) Street No. 1607 S. Stewart 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME 351 Bessie Allison Stanfield  
 (a) Residence, No. 1607 S. Stewart 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 (*write the word*) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 21, 1889

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>50</u>	<u>          </u>	<u>2</u>	<u>22</u>	<u>          </u>

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. At home  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

FATHER  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pilot Grove Missouri  
 13. NAME William T. Meredith  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pilot Grove Missouri

MOTHER  
 15. MAIDEN NAME Foremin  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Charles Missouri

17. INFORMANT (ADDRESS) A. P. Stanfield Sedalia, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE January 16, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gillespie Funeral Home Sedalia, Missouri

20. FILED Jan 16 1940 Mrs. Harry Sneed Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 13, 1940

22. I HEREBY CERTIFY, That I attended deceased from for last 2 years, to Jan 13, 1940, 1940  
 I first saw her live on Jan 13, 1940 Death is said to have occurred on the date stated above, at 5:30 P.  
 The principal cause of death and related causes of importance were as follows:  
Carcinoma of Soft Maxillary Sinus and Soft Orbit  
 Date of onset over 2 years ago

Other contributory causes of importance: 578

Name of operation None - X Ray and Radium  
 What test confirmed diagnosis? at Quinsy Hospital at Quinsy, Mo

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) Just B. Carlisle M.D. M. D.  
 Address Sedalia 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.

**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 comply with the above constitutes grounds for revocation of license.)**

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