

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

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.

APR 23 1940

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

11645
Do not use this space.

1. PLACE OF DEATH

(a) County macon Registration District No. 533
 (b) Township Hudson Primary Registration District No. 57b3
 (c) City macon (d) Street No. Still-Hillwell Sanatorium Registered No. 24
 (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

(a) Residence, No. 351 Mrs. Gay Stanfield
Farmington, Mo. 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 wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mr. L. M. Stanfield

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 20, 1904

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>36</u>	<u>0</u>	<u>3</u>		

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. Housewife
 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) Mo. D.

FATHER 13. NAME J. A. Kite

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jefferson Co Mo D

MOTHER 15. MAIDEN NAME Sara Ferguson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Genevieve Co Mo D

17. INFORMANT (ADDRESS) Dr. L. M. Stanfield Farmington Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Removal DATE 3/23 1940

19. FUNERAL DIRECTOR (ADDRESS) Walter H. Spunner Macon, Mo.

20. FILED 4/2 1940 Geo. H. Kewell Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 23, 1940

22. I HEREBY CERTIFY, That I attended deceased from March 10, 1940, to March 23, 1940
 I last saw her alive on March 23, 1940 Death is said to have occurred on the date stated above, at 4:30 a.m.

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

Lobar Pneumonia Date of onset Mar 20
Acute Endocarditis with Psychosis
 10/8

Other contributory causes of importance:
Acute Endocarditis with Psychosis

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) Anna L. Mauck M. D.
macon, Mo

FEB 14 1947

RECEIVED

District Health Officer No. 10

District File Number 4-40-767

Date Filed APR 9 1940

STATEMENT BY LICENSED EMBALMER

I, *George Phile* Licensed Embalmer No. 4066

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 *George Phile*
Licensed Embalmer No. 4066

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.)