

FILED SEP 16 1940

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

28109

Do not use this space.

## 1. PLACE OF DEATH

(a) County Caldwell Registration District No. 941  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4655 Registered No. \_\_\_\_\_  
 (c) City Breckenridge (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 8 1/2 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

(a) Residence, No. 325 Little Stagner Breckenridge Mo.  \_\_\_\_\_ (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 male 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 Mary M. Stagner  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 16 - 1885  
 7. AGE YEARS 84 MONTHS 9 DAYS 25 If LESS than 1 day, .....hra. or .....min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Madison Co. Ky.  
 (STATE OR COUNTRY)

FATHER 13. NAME James Stagner  
 14. BIRTHPLACE (CITY OR TOWN) Ky.  
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Charlotte Ellidge  
 16. BIRTHPLACE (CITY OR TOWN) Ky.  
 (STATE OR COUNTRY)

17. INFORMANT R. W. Stagner  
 (ADDRESS) Chillicothe Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Rose Hill DATE Aug 12 1940

19. FUNERAL DIRECTOR (NAME) A. P. Wilsey  
 (ADDRESS) Breckenridge Mo.

20. FILED Aug 12, 1940 A. P. Wilsey MD  
 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 10th 1940

22. I HEREBY CERTIFY, That I attended deceased from April 15th, 1940, to August 10th, 1940.

I last saw him alive on Aug. 10th, 1940. Death is said to have occurred on the date stated above, at 3-45Pm.

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

Cancer of Rectum and anus ✓

Date of onset  
1939

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Symptoms Was there an autopsy? no.

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 no.

(Signed) A. P. Wilsey MD M. D.  
 (Address) Breckenridge, Missouri.

46  
RECEIVED  
District Health Officer No. 11,  
District File Number 9  
Date Filed SEP 16 1968 - L.S.R.

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,

*T. F. McBeck*

, or by

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

Signed *T. F. McBeck*

Licensed Embalmer No. *1570*

P. O. Address *Breckinridge*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 281097

Registration District No. 94

Primary Registration District No. 40536

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County. Caldwell  
(b) City or town. Breckenridge  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether

In this community. \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME. Lytle Stagner

3. (b) If veteran, name war. \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife. \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive. \_\_\_\_\_ years

7. Birth date of deceased. \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 84 Months 9 Days 25 If less than one day \_\_\_\_\_ min.

9. Birthplace. \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

{ 13. Birthplace. \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

{ 14. Maiden name. \_\_\_\_\_

{ 15. Birthplace. \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof. \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. \_\_\_\_\_ (b) County. \_\_\_\_\_

(c) City or town. \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month 8 day 10 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death. Cancer of Rectum anus

Due to. unknown - as I only

Due to. See him three weeks and not make a thorough

Other conditions. Examine as death was near  
(include pregnancy within 3 months of death)

Major findings: Of operations. 46

Of autopsy. \_\_\_\_\_

Duration 2 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

