

Registration District No. **104**

Primary Registration District No. **3008**

Registrar's No. **205**

FILED SEP 16 1940

1. PLACE OF DEATH

(a) County **Callaway**
 (b) City or town **Fulton, mo**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **State Hospital #1**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **4 yrs - 4 mos.**
 (Specify whether)

In this community **2 1/2** years, months or days

3. (a) PRINT FULL NAME **CYRUS STANLEY**

3. (b) If veteran, name war **DK** 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 18 1861**
 (Month) (Day) (Year)

8. AGE: Years **79** Months **1** Days **28** If less than one day hr. min.

9. Birthplace **Indiana**
 (City, town, or county) (State or foreign country)

10. Usual occupation **salesman**

11. Industry or business **traveling salesman**

MOTHER FATHER

12. Name **H. C. Stanley**

13. Birthplace **Indiana**
 (City, town, or county) (State or foreign country)

14. Maiden name **Sophronia Besson**

15. Birthplace **Indiana**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Records**

(b) Address **State Hosp #1**

17. (a) **Removal** (b) Date thereof **8/15/40**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Funerary home**

18. (a) Signature of funeral director **[Signature]**
 (b) Address **Mexico, mo.**

19. (a) **Aug. 15, 1940** (b) **R. D. Creese**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Andrain**
 (c) City or town **Mexico, mo**
 (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 **aug** day **15**
 year **1940** hour **1.0** minute **20 A.M.**

21. I hereby certify that I attended the deceased from **July 1 1939**
 _____, 19____, to **aug 15 1940**
 that I last saw him alive on **aug 15 1940**
 and that death occurred on the date and hour stated above.

Immediate cause of death **fracture of neck of left femur** **aug 11 1940**
 Duration **8 1/2 hrs.**

Due to **Fall**
 Due to **1 1/2 hrs**

Other conditions **Generalized arteriosclerosis**
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy **not done**
 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) **accident**
 (b) Date of occurrence **aug 11, 1940**
 (c) Where did injury occur? **Fulton Callaway mo**
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Alum hospital work
 While at work? **no** (Specify type of place) (e) Means of injury **Fall**

23. Signature **J. Blasko MD** (M. D. or other) **1**
 Address **Fulton, mo** Date signed **8/15/40**

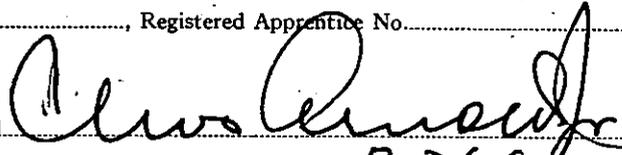
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

3569

P. O. Address

Murphy, N.C.

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.)

If this body is not embalmed, fact should be so stated above.