

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31665

Registration District No. 143

Primary Registration District No. 5205

Registrar's No.

1. PLACE OF DEATH: (a) County Carter (b) City or town Sumner (c) Name of hospital or institution: _____ (If outside city or town limits, write "RURAL" and name of township) (d) Length of stay: In hospital or institution 20 (Specify whether _____) (e) In this community _____ years, months or days

3. (a) PRINT FULL NAME BABY STANDLEY (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____ (b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 9/9/40 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Catoxi (City, town, or county) (State or foreign country) MS

10. Usual occupation _____

11. Industry or business _____

12. Name Tom Standley 13. Birthplace Cassidy (City, town, or county) (State or foreign country) Ill

14. Maiden name Maureen 15. Birthplace Catoxi (City, town, or county) (State or foreign country) MS

16. (a) Informant's own signature _____ (b) Address _____

17. (a) Funeral (b) Date thereof 9/21/40 (Burial, cremation, or removal) (Month) (Day) (Year) (c) Place: burial or cremation Proceda, Mo.

18. (a) Signature of funeral director Wm. J. Leuschel (b) Address West Sumner 19. (a) 9-21-40 (b) M. Gallon (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: (a) State Mo (b) County _____ (c) City or town South Van Buren (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 9 day 17 year 40 hour _____ minute 2:30 PM

21. I hereby certify that I attended the deceased from 8 am to 2:30 P.M. - 9/17/40 and that death occurred on the date and hour stated above.

Immediate cause of death Congenital debility Duration since birth

Due to _____ 158

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy _____ 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? 125 (Specify type of place) (e) Means of injury _____

23. Signature M. Gallon (M. D. or other) 1 Address Van Buren Date signed _____

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.

RECEIVED

District Health Officer No. 5,

District File Number 1040973

Date Filed _____

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

J. Allen Lewis

Licensed Embalmer No.

4053

P. O. Address

Van Buren

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

State File No. **3166J-7**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **143**

Primary Registration District No. **5205-**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County **Carter**
(b) City or town **Carter T. P.**
(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 **Baby Standley**

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

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced _____

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 _____ Months _____ Days **8** If less than one day _____ min.

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

10. Usual occupation **Selling & delivering** _____ (Industry or business)

11. Industry or business _____

12. Name **Jon Standley**

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

14. Maiden name **Geneva Carter**

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

16. (a) Informant **Mr. Standley**

(b) Address **Home, Osceola, Mo.**

17. (a) **Buried** (b) Date thereof **9/21/40**
(Burial, cremation, or removal) _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation **Osceola, Mo.**

18. (a) Signature of funeral director **Cray - Luchel**

(b) Address **Van Buren**

19. (a) **9-21-40** (b) **J. W. Cotton**
(Date received local registrar) _____ (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 **9** day **17**
year _____ hour _____ minute _____ M.

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

Immediate cause of death _____
Duration _____

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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 _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature **J. W. Cotton** (M. D. or other) _____
Address **Van Buren** D **2000**

